A Report
to the
Montana
Legislature

Performance Audit

Montana Developmental Center Closure and Client Transition

Department of Public Health and Human Services

May 2021

Legislative Audit
Division

19P-02

Performance Audits

Performance audits conducted by the Legislative Audit Division are designed to assess state government operations. From the audit work, a determination is made as to whether agencies and programs are accomplishing their purposes, and whether they can do so with greater efficiency and economy.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Members of the performance audit staff hold degrees in disciplines appropriate to the audit process.

Performance audits are conducted at the request of the Legislative Audit Committee, which is a bicameral and bipartisan standing committee of the Montana Legislature. The committee consists of six members of the Senate and six members of the House of Representatives.

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LEGISLATIVE AUDIT DIVISION

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May 2021

The Legislative Audit Committee
of the Montana State Legislature:

This is our performance audit of the Montana Developmental Center (MDC) closure managed by the Developmental Services Division of the Department of Public Health and Human Services (DPHHS).

This report provides the legislature information about MDC closure activities, former MDC clients, their transition processes and how they are doing now, and the costs of serving former clients in the community compared to MDC. This report includes recommendations for adhering to client monitoring requirements, developing a repurposing plan for the vacant MDC facility, creating a memorandum of understanding with the Department of Justice to clarify Intensive Behavior Center incident reporting processes, improving client plan of care processes, and developing a data management plan for collecting and analyzing client data. A written response from DPHHS is included at the end of the report.

We wish to express our appreciation to DPHHS personnel for their cooperation and assistance during the audit.

Respectfully submitted,

/s/ Angus Maciver

Angus Maciver
Legislative Auditor

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Table of Contents

Figures and Tables

Figures

Tables

Appointed and Administrative Officials

Department of Public Health and Human Services	Adam Meier, Director (effective January 2021)
	Erica Johnston, Acting Director (November 2020 – January 2021)
	Sheila Hogan, Director (through November 2020)
	Marie Matthews, Manager, Medicaid and Health Services Branch
	Rebecca de Camara, Administrator, Developmental Services Division

Performance Audit 19P-02 May 2021

Montana Legislative Audit Division

Montana Developmental Center Closure and Client Transition

Department of Public Health and Human Services

Background

The Montana Developmental Center (MDC) served as a placement of last resort for adults with serious developmental disabilities. At the direction of the legislature, the Department of Public Health and Human Services closed MDC in October 2018. The Intensive Behavior Center (IBC), a 12-bed secure facility, still operates on the same grounds in Boulder, Montana.

Agency:
Department of Public Health and Human Services

Director:
Adam Meier

Programs:
Montana Developmental Center
Intensive Behavior Center
Developmental Disabilities Program

Division:
Developmental Services Division

Branch:
Medicaid and Health Services

Closing the Montana Developmental Center required the Department of Public Health and Human Services (DPHHS) to balance multiple closure activities while transitioning clients out of the facility. We found clients' closure placements have remained stable; 35 of 53 former MDC clients currently receive services from Montana community providers. Former clients surveyed generally indicated they feel safe where they live and are happy. We found that serving clients in the community costs less than serving them at MDC.

KEY FINDINGS:

Closing MDC was a complex endeavor for the department, complicated by an accelerated timeline and multiple responsibilities. The department prioritized ensuring successful client transitions. The opportunity to plan for the closure prior to its commencement, as some other states have done, may have led to a more streamlined process.

DPHHS fulfilled most statutory closure requirements. Mandates from the 2015 and 2017 Legislative Sessions placed limitations on facility and funding use, and established client transition deadlines and client monitoring requirements. DPHHS engaged in good faith efforts to meet these requirements.

Consistency of the closure client transition process was impacted by the organizational environment and efforts to transition many clients simultaneously. Since transitioning, most former clients who enrolled in community services are still receiving services. Most other placements have also remained stable.

Idle MDC facilities are not efficient use of state resources. DPHHS estimates it will cost approximately $660,000 to maintain the empty MDC facilities for fiscal year 2021. The idle facilities are maintained with budgetary resources that could otherwise support the department's mission.

More incidents of abuse, neglect, mistreatment, or injury of unknown source occurred at MDC than in community. We examined incidents involving 36 clients in the two years before and after they discharged from MDC to community providers. We found significantly more of these incident types occurred at MDC than in the community; however, differences between the two incident reporting systems, including that MDC/IBC is held to higher reporting expectations, impact the ability to use incident reports as a proxy for measuring client safety.

We found it **costs less to serve former MDC clients in the community** under the state's Home and Community-Based Services Medicaid Waiver for individuals with developmental disabilities than at MDC. However, we found that, generally, it costs significantly more to serve former MDC clients under the waiver than the average waiver recipient due to their need for greater supports.

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RECOMMENDATIONS:

In this report, we issued the following recommendations:

To the department: 5
To the legislature: 0

Recommendation #1 (page 16):
Reporting to Families/Guardians
We recommend the Department of Public Health and Human Services continue to adhere to state law by maintaining a process to report clients' monitoring results to guardians and family members authorized to receive the information.
Department response: Concur

Recommendation #2 (page 21):
Repurposing Plan
We recommend the Department of Public Health and Human Services develop a repurposing plan for the MDC facility that identifies key information, such as action steps, timelines, benchmarks to measure completion, and parties responsible for each step.
Department response: Partially Concur

Recommendation #3 (page 46):
IBC Incident Reporting Coordination
We recommend that the Department of Public Health and Human Services work with the Department of Justice to develop and maintain a memorandum of understanding that clearly defines agency and staff roles, expectations, and processes for Intensive Behavior Center incident reporting.
Department response: Concur

Recommendation #4 (page 53):
Person-Centered Planning
We recommend the Department of Public Health and Human Services:

A. Update and centralize policies, procedures, and/or administrative rules for Personal Support Plans to increase administrative efficiencies, ensure greater consistency, and reflect person-centered planning.
B. Provide ongoing, statewide training for case managers and providers regarding policies, procedures, and administrative rules.
C. Monitor Personal Support Plans for adherence to requirements to help ensure ongoing person-centered planning across regions and providers.

Department response: Concur

Recommendation #5 (page 57):
Data Management
We recommend the Department of Health and Human Services Developmental Services Division develop a data management plan and processes to:

A. Identify data needs for measuring and aggregating client outcomes.
B. Develop protocols for collecting reliable and accurate data.
C. Ensure more consistent and centralized data storage.
D. Establish analysis procedures and reports to make informed management decisions and inform stakeholders on client outcomes.

Department response: Concur

Chapter I – Introduction and Background

Introduction

Operated by the Developmental Services Division (DSD) of the Department of Public Health and Human Services (DPHHS, department), the former Montana Developmental Center (MDC) was the only Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) in Montana. It served adults with serious developmental disabilities civilly or criminally committed due to posing an imminent risk of harming themselves or others. MDC closed on October 26, 2018 as the result of a legislative mandate. The Intensive Behavior Center (IBC), a 12-bed, secure facility, still operates on the property. The IBC functions as a placement of last resort for individuals with serious developmental disabilities. The property on which the former MDC facility and the current IBC facility sit is referred to as the Boulder campus.

Due to questions from legislators surrounding the facility's closure and the wellbeing of former MDC clients, the Legislative Audit Committee prioritized a performance audit of the closure and DPHHS's role in transitioning clients from MDC into community-based settings. We conducted the audit to determine whether the department followed statutory closure requirements and understand whether former MDC clients have experienced improved safety and community inclusion outcomes in the community. The audit also assessed whether MDC's closure has resulted in cost savings to the state. This chapter outlines the history of MDC, the origins of MDC's closure, and the process of transitioning clients to alternative placements.

Brief History of MDC

Located in Boulder, Montana, MDC originated in 1905 as the School for the Feeble Minded and transitioned into an institution in 1956. Its census peaked at 1,101 less than a decade later. A push for deinstitutionalization beginning in the 1970s saw the start of a steady census decline. The facility experienced ongoing challenges beginning in the 1990s, including lawsuits and a U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services finding that clients were at risk for serious harm. In 2010, a former MDC employee was convicted of sexually assaulting a client. These safety concerns were a primary reason the legislature mandated MDC's closure. Legislative action related to the closure are discussed in Chapter II of this report.

MDC was a placement of last resort for adults with serious developmental disabilities (DD). A person who is seriously developmentally disabled is one who has a DD, is impaired in cognitive functioning, and cannot be safely and effectively habilitated through voluntary use of community-based services because of behaviors that pose an imminent risk of serious harm to self or others. Clients were committed to MDC under

civil or criminal court commitments and some remained there after their commitment expired to voluntarily continue treatment while awaiting community placement.

The Boulder campus consists of 52 acres with at least 20 buildings with purposes spanning client residences and treatment, administration, and maintenance. Prior to the closure, there were two distinct facilities in operation on the campus:

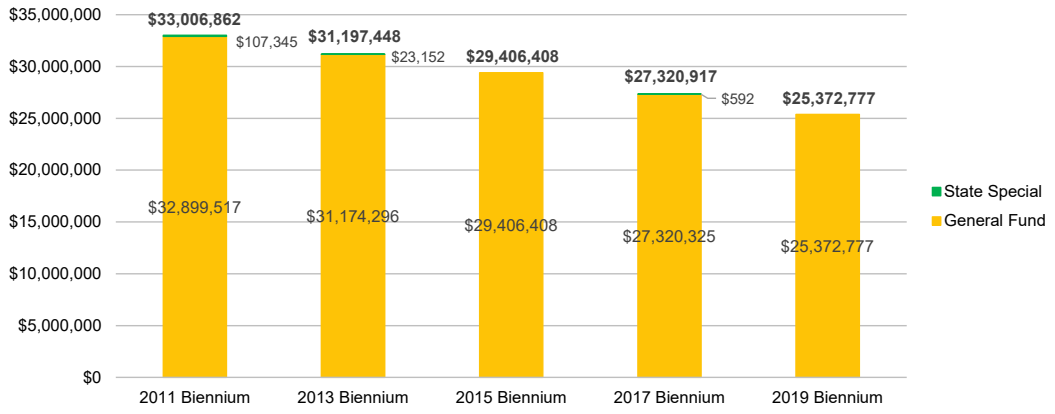
- **MDC:** A residential ICF-IID facility with an open campus.
- **Assessment and Stabilization Unit (ASU):** A 12-bed secure Intermediate Care Facility for the Developmentally Disabled built in 2005 and regulated separately from MDC.

MDC Organization and Funding

The MDC/IBC is organized as a unit under the DSD. The DSD also oversees three bureaus, including the Developmental Disabilities Program (DDP). The DDP provides services to eligible people of all ages with developmental disabilities, including administering the state's 1915(c) Home and Community-Based Services Medicaid Waiver for individuals with intellectual/developmental disabilities (waiver). DDP staff work with MDC/IBC when an individual enters waiver services upon discharging.

Legislative appropriations for MDC declined over time. This decline was in part a response to the closure mandate, as the legislature expected less costs to serve fewer clients. Figure 1 shows legislative appropriations by fund type for MDC for the 2011 through 2019 biennia. General Fund is represented in yellow and green captures the State Special Revenue Fund.

Figure 1
MDC Total Appropriations Declined Over Time



Source: Compiled by the Legislative Audit Division based on appropriations data.

General Fund appropriations for MDC declined 23 percent between the 2011 and 2019 biennia and, while minimal, State Special Revenue Fund appropriations declined

as well. General Fund appropriations for the 2019 biennium decreased $1.9 million from the previous biennium, as the MDC's closure was expected to occur that period.

In addition to operating IBC, DSD maintains the vacant MDC grounds. It splits these two areas of operational focus in its budget to track expenditures for each area separately. In fiscal year (FY) 2019, during which MDC closed, the total expenditures of MDC and IBC operations were $5.9 million. Boulder campus maintenance expenditures in FY 2019 were $1.1 million. Table 1 captures the expenditures for operating IBC and maintaining the Boulder campus in FY 2020, the first full fiscal year following MDC's closure.

Table 1
Fiscal Year 2020 Department Operations Expenditures in Boulder

Operations Focus	FY 2020 Expenditures	Percent of Total
IBC 12-Bed Facility	$4,587,288	85%
Boulder Campus Maintenance	$782,186	15%
Total	$5,369,474	100%

Source: Compiled by Legislative Audit Division staff based on SABHRS data.

For FY 2020, approximately 15 percent of total expenditures were used for maintaining the inactive MDC facility and campus grounds. The department reports the current full-time equivalent (FTE) for all Boulder operations is 71.41. Seven FTE are dedicated to the Boulder Campus maintenance and 64.41 FTE are dedicated to operating the IBC facility. Total FTE at Boulder decreased significantly as a result of MDC's closure, as 105.26 FTE were transferred from MDC to other DPHHS divisions.

Legislature Mandated MDC's Closure

Legislative efforts to close MDC began during the 2013 Legislative Session and were successful during the 2015 Legislative Session. Chapter 444, 2015 Session Laws (Senate Bill [SB] 411) was the initial MDC closure bill; it set June 30, 2017 as the closure deadline. At the time SB 411 was signed into law, there were 53 individuals committed to the Boulder campus. This law also created a 15-person temporary transition planning committee called the MDC Transition Planning Advisory Council. The council consisted of 15 members representing stakeholder groups and was charged with assisting the department in developing a closure plan and advising on specific aspects of the closure, such as identifying repurposing options for the MDC campus. Because it was clear the department needed more time to close MDC, subsequent legislative action in the 2017 session extended the closure deadline to June 30, 2019. This was done at the recommendation of the council. The 2017 Legislature also established the

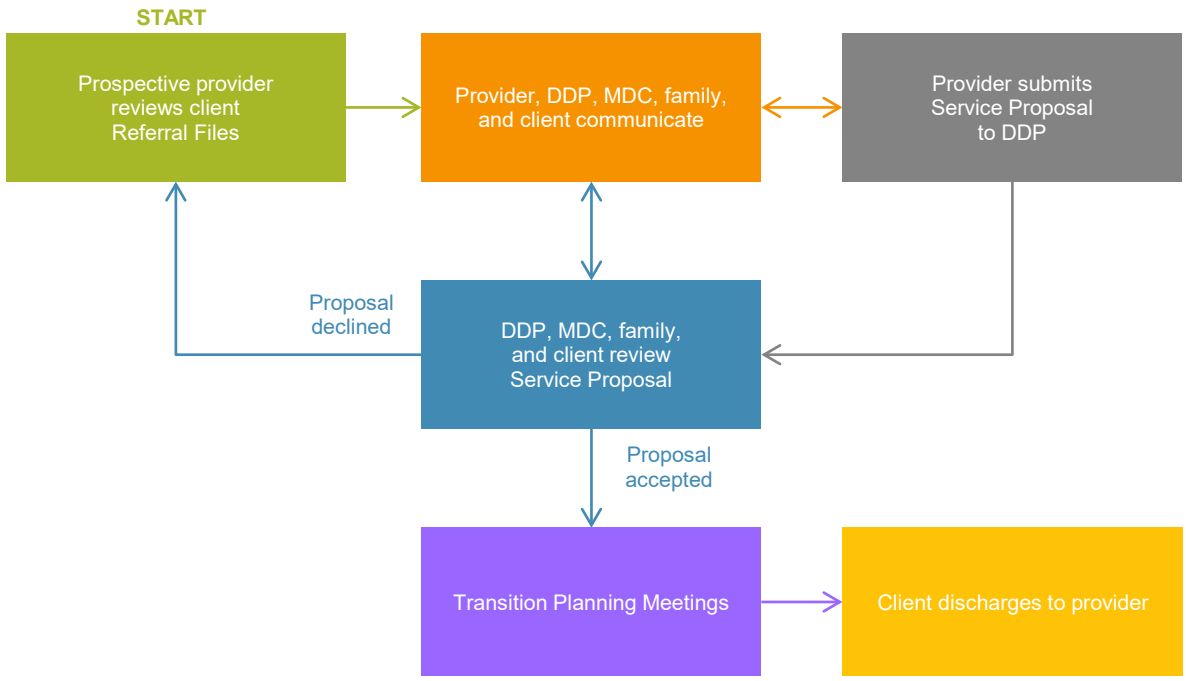
conversion of the ASU into the IBC. Legislative closure requirements and the role of council are discussed in Chapter II of the report.

Transitioning Clients to Community Providers

Transitioning clients out of MDC was the primary closure focus of the department. The transition process for those discharged to community providers was complex and required regular communication across stakeholders. While the closure transition process was not unique to MDC's closure, DDP staff took on a more involved, intensive role to help secure and ensure successful placements for clients, as returning to MDC was not possible after it downsized and closed.

Figure 2 illustrates the major transition process steps for individuals discharged from MDC/IBC to community service providers. More details about each major step follow the figure.

Figure 2
Client Transition to Community Provider Required Regular Communication



Source: Compiled by Legislative Audit Division staff based on department documents and interviews.

The transition process typically began with prospective providers reviewing referral files compiled by department staff from various MDC treatment and assessment documents. Referral files helped providers decide whether to explore further if a client would be a good fit for them. An interested provider often engaged DDP and MDC staff to get to know a client, including requesting temporary access to a client's records or meeting the client.

If the provider desired to serve an individual, they submitted a service proposal. An application, the service proposal required providers to describe how they would meet the client's residential, health and safety, and vocational needs. Prospective providers also estimated the cost of serving the individual. This leg of the process involved additional communication between the provider, DDP, and MDC.

MDC staff, family members, and usually the client then met to review a service proposal and decided whether the provider and placement were a good fit for the individual. As needed, DDP staff followed up with the provider with questions from the review. Once a service proposal was accepted, MDC staff organized transition planning meetings during which transition details for the individual were solidified, including finalizing the individual's waiver cost plan and the specific services to be delivered.

Audit Scope

Audit assessment work identified several potential risks related to serving the small but vulnerable population of individuals with serious DD at MDC. Risk areas included the statutory closure mandates that evolved across two legislative sessions and established an accelerated closure process not preceded by departmental or legislative planning. While the department created a closure plan, it did not incorporate detailed, written steps delineating how closure was to be achieved. Consequently, we examined whether the department satisfied statutory closure requirements, including the roles played by the department and the MDC Transition Planning Advisory Council, and the current status of the Boulder campus facilities.

Legislative and stakeholder interest during and after the closure focused in large part on the welfare of former MDC clients, including whether the closure affected safety and inclusion outcomes for former MDC clients. As a result, we focused our work on determining the status of these individuals. We also reviewed plans of care and incident reports from both MDC and community providers to identify trends related to client safety and quality of care in both settings. Further, institutional closures are often predicated on the cost effectiveness of serving individuals with DD in the community. As a result, we also completed a cost analysis to determine if placing former MDC clients outside of the MDC facility has resulted in cost savings.

Audit Objectives

Based on our audit assessment work, we developed the following audit objectives as part of our examination of the MDC closure:

- Did DPHHS follow applicable statute and policies, as well as closure strategies used by other states, in closing MDC and transitioning clients to alternative placements?

- Has MDC's closure ensured safety and community inclusion outcomes for former clients?
- Has serving former MDC clients in alternative placements resulted in cost savings for the state?

Audit Methodologies

To accomplish our work, we completed the following methodologies:

- Reviewed relevant state laws, administrative rules, and department policies and procedures.
- Reviewed MDC Transition Planning Advisory Council recordings and associated materials to determine the role it played in the closure and whether it met statutory requirements.
- Interviewed department staff and former council members and compiled relevant department documents to identify key closure milestones and issues.
- Toured the Boulder campus to confirm MDC's closure and understand the facility changes that resulted from the closure.
- Identified the current status of the 53 clients at the MDC facility at the time of the closure statute was signed into law.
- Reviewed transition documents for the 46 individuals who transitioned out of Boulder during the closure to assess the consistency of the transition process.
- Interviewed community service providers serving former MDC clients to hear their experiences during the closure and serving these individuals.
- Interviewed staff from other states that closed state-run developmental centers to identify best practices and common challenges related to closing facilities and serving individuals in community settings.
- Reviewed waiver individual cost plans and Medicaid medical claims for 42 individuals of the group of 53 who had waiver and/or medical claims between their MDC discharge date and June 30, 2019, to determine the average annual cost to serve these clients in the community.
- Analyzed department client monitoring data to determine statutory adherence and identify any changes in clients' skills, abilities, and behaviors.
- Reviewed and analyzed Individual Treatment Plans, Personal Support Plans, and quarterly provider progress reports for the 38 individuals from the cohort who transitioned to waiver services to determine the department's adherence to its policies and procedures and assess client progress from MDC into the community.
- Analyzed MDC and community provider incident reports involving allegations of mistreatment/exploitation, neglect, abuse, or injuries of unknown source.

- Surveyed cohort members and the family members and guardians that support them to learn how they are doing now and hear about their experiences at MDC and during their transition to the community.
- Contracted with an outside consultant with experience and expertise working with adults with disabilities to aid in our survey development and review of our analyses of client safety and inclusion outcomes.

Issue for Further Study

Over the course of our work, a common concern discussed by stakeholders was that MDC's closure has increased gaps in the state service system for adults with DD, particularly for those who are dually diagnosed with a mental illness and/or who are experiencing a crisis. Both providers and department staff believe the current statewide care infrastructure for adults with DD cannot adequately aid individuals in crisis. MDC's closure has led to fewer placements of last resort available for individuals and the 12-bed IBC facility experiences low turnover. A future performance audit could examine current avenues through which individuals in crisis can access timely stabilization care, the level of need across the state for these services, and whether developing a statewide crisis response system or additional community service resources could result in less disruption for individuals experiencing crisis and their providers.

Report Contents

The remainder of this report includes additional detail about the MDC closure and details our findings, conclusions, and recommendations.

- Chapter II outlines MDC closure milestones and activities and whether the department and MDC Transition Planning Advisory Council met statutory closure requirements.
- Chapter III discusses where cohort clients were placed as a result of the closure, the client transition process, and results of the client and natural supports surveys.
- Chapter IV describes our analyses of client statutory monitoring data, incident reporting at MDC/IBC and community providers, and client plans of care from the community and MDC.
- Chapter V addresses costs of serving clients in the community and at MDC/IBC.

Chapter II – Closure Milestones and Statutory Adherence

Introduction

Our first audit objective focused on determining if the Department of Public Health and Human Services (department) followed applicable statute and policies, as well as closure strategies used by other states, in closing the Montana Developmental Center (MDC) and transitioning clients to alternative placements. During the closure period, the department contended with declining appropriations, multiple statutory expectations, and increasing organizational instability at Boulder. Because of the accelerated closure timeline, the department prioritized transitioning clients out of MDC and ensuring clients' success in their new homes. The department balanced supporting the 15-member MDC Transition Planning Advisory Council (council) and other closure tasks required by the legislature. Regardless, our work found the department closed the facility timely and adhered to most closure-related statute. We determined two statutory requirements were not satisfied.

This chapter provides information on the MDC closure, statutory closure requirements and whether the department and council met them, and the need to develop a plan for repurposing the idle MDC facility. This chapter also includes our associated conclusions, findings, and recommendations.

MDC Closure Milestones and Activities

The 2015 Legislature directed the department to close MDC by June 30, 2017, and develop and implement a closure plan based on recommendations from the council it established. The council's 15-person membership included representatives from the executive and legislative branches, community service providers, the MDC workforce, and several advocacy organizations and client family members. The 2015 session also required the department to transition most clients by December 31, 2016 and did not permit emergency or court commitments to MDC beyond that same date.

The 2017 Legislative Session generated additional MDC closure mandates. It extended the initial 2017 closure deadline to June 30, 2019; this was done at the recommendation of the council, as it was clear the department could not realistically meet the original closure deadline. Further, it established converting the Boulder campus secure Assessment and Stabilization Unit (ASU) into the Intensive Behavior Center (IBC). The IBC was statutorily capped at 12 beds. Further 2017 legislative efforts included limiting clients' IBC commitment period to 90 days, requiring clients be recommitted each period. At the council's suggestion, the legislature also established

a $500,000 fund to help mitigate potential economic impacts MDC's closure might have on Boulder. Statutory closure requirements from both 2015 and 2017 Legislative Sessions are discussed in more detail later in this chapter.

During the closure period, the department had to balance multiple closure-related endeavors, including:

- Transitioning clients out of the facility,
- Consolidating and closing physical facilities,
- Addressing workforce issues,
- Managing multiple statutory mandates, and
- Monitoring clients at MDC and in the community.

The following sections discuss each of these major areas the department had to manage as a part of coordinating the facility closure.

Department Focused on Transitioning Clients Out of MDC During Closure

There were 53 individuals at MDC when the closure legislation was signed into law. The department's priority during closure was obtaining and arranging successful placements for these clients. To do so, staff from the Developmental Disabilities Program (DDP) Helena central office took on a more intensive and proactive role in the transition process, as discussed in the previous chapter.

DDP Helena staff also took on case management responsibilities for individuals from the cohort of 53 who enrolled in the state's 1915(c) Home and Community-Based Services Medicaid Waiver for individuals with intellectual/developmental disabilities (waiver). Waiver clients are typically assigned case managers from the DDP region in which they reside. However, to help ensure clients experienced success in their new placements or services, these staff engaged in more intensive post-transition oversight than is expected of the average waiver client's case manager.

Per department management, clients with less significant support requirements were the first to secure community-based placements. The department indicated some community providers were hesitant to accept MDC clients with greater needs. As such, the department contracted with a large, out-of-state community provider that agreed to establish services in Montana to serve some MDC clients. Thirteen clients from the cohort transitioned to this provider. The department also contracted with an in-state provider to transition a large group of clients. Both providers, as well as others that accepted MDC clients, received one-time stipends funded by federal social services

grant funds for each person they accepted into services; these stipends funded client-related supports, such as staff training or enhancing accessibility for the individual.

Department Consolidated Physical Facilities During and After the Closure

As individuals transitioned out of MDC, the department closed client cottages, the residential buildings in which MDC clients lived. At the outset of the closure, five of the six cottages on the Boulder campus housed clients. One cottage shuttered prior to the closure due to reduced funding. Three cottages closed in 2016. The department met statutory cottage closure timelines for the remaining two cottages in 2018. Closing and consolidating cottages was necessary in part to maintain minimum client-to-staff ratios, as clients spread across multiple cottages required more direct care staff to maintain the ratios and retaining employees and recruiting new ones were areas of difficulty given the facility's pending closure.

Department Managed a Declining Workforce

The department also had to address MDC workforce issues during the closure, including staff morale and attrition due to organizational instability. In response, the department implemented employee retention strategies, including double overtime rates to help ensure minimum required staffing was maintained to serve clients. One of the primary employee unions negotiated for $500 retention bonuses and incentives for employees close to retirement.

As a result of the closure, 87.26 FTE positions from MDC were transferred to other department divisions during the 2019 biennium; these FTE vacancies came from a combination of reductions-in-force and employee attrition. Eighteen additional FTE were transferred from MDC as a part of the 2021 biennium budget proposal; the department indicated all 18 individuals formerly employed within these FTE positions were either placed into other positions or retired. The IBC currently employs 71.41 FTE: seven FTE are dedicated to Boulder campus operations and 64.41 FTE to the operations of the 12-bed IBC facility, including direct client care and treatment and administrative functions.

To maintain core administrative and client care functions with downsized facilities and workforce, the department centralized some services in Helena, contracted out for other services, or combined responsibilities of formerly separate MDC divisions and positions. For example, while the MDC facility used a full commercial kitchen and dietary staff, the kitchen is now idle, and food and dietitian services are contracted out.

Department Fulfilled Most Closure Requirements

As part of our work, we examined whether the department and council met the statutory closure expectations generated by the 2015 and 2017 Legislatures. Table 2 outlines the department's statutory requirements and our determinations as to whether they were met. Evaluation of the council's statutory fulfillment follows in a subsequent section of this chapter.

Table 2
The Department Fulfilled Most Statutory Closure Requirements

Statute	Statutory Requirement	Satisfied?	Notes
Ch. 444, Sec. 1, L. 2015 (SB 411)	Develop and implement plan to close MDC	✓ Yes	However, not all planned strategies implemented.
Ch. 444, Sec. 4, L. 2015 (SB 411)	Transition most residents into community-based services by December 31, 2016	✗ No	Forty-nine percent transitioned to community-based services by deadline.
§53-20-125, MCA §53-20-129, MCA	No emergency or commitments to MDC after December 31, 2016	✓ Yes	
Ch. 258, Sec. 6, L. 2017 (HB 387)	Close MDC by June 30, 2019	✓ Yes	
Ch. 444, Sec. 4, L. 2015 (SB 411)	Assess fee on providers who return an individual in 90 days	Not Applicable	No individuals returned to MDC.
Ch. 258, Sec. 10, L. 2017 (HB 387)	Administer the Boulder Development Fund	✓ Yes	Fund was disbursed in accordance with legislative intent. However, department transferred fund administration to Department of Commerce.
Ch. 364, Sec. 2, L. 2017 (HB 639)	MDC HB 2 appropriations restricted; must notify legislature of transfers	✓ Yes	
Ch. 258, Sec. 6, L. 2017 (HB 387)	Cap MDC census and cottage use; cap IBC census	✓ Yes	
Ch. 265, Sec. 5, L. 2017 (HB 458)	Monitor clients for two years	✓ Yes	Clients were/are monitored for two years but some not within defined timeline.
§53-20-225(3), MCA	Report monitoring results to family/guardians and interim legislative committee	✗ No	Department did not report results to family/guardians.

Source: Compiled by Legislative Audit Division staff based on department interviews and data.

As outlined in the table, the department met most statutory requirements related to MDC's closure. MDC closed eight months ahead of its deadline. Census data and facility closure documentation confirmed census maximums and cottage closure deadlines were honored. The only known person committed to the Boulder campus after the statutory deadline was committed to the 12-bed secure facility rather than MDC. A review of a sample of MDC expenditures for fiscal years 2018 and 2019 and budget change documents, as well as discussions with legislative staff, confirmed the department adhered to 2019 biennium appropriations restrictions and associated requirements.

The 2017 Legislature created a $500,000 Boulder Developmental Fund to help mitigate potential economic impacts of the closure on Boulder. To leverage their expertise, the department developed a memorandum of understanding with the Montana Department of Commerce (Commerce) for assistance managing the fund.

At Commerce's guidance, a Boulder community group submitted project proposals approved by Commerce based on the determination they would contribute to Boulder's community or economic development. In all, 15 projects were approved, including the installation of bike racks, downtown façade improvements, and upgrades for a park and city hall. While the fund was disbursed in accordance with legislative intent, the department transferred fund administration to Commerce.

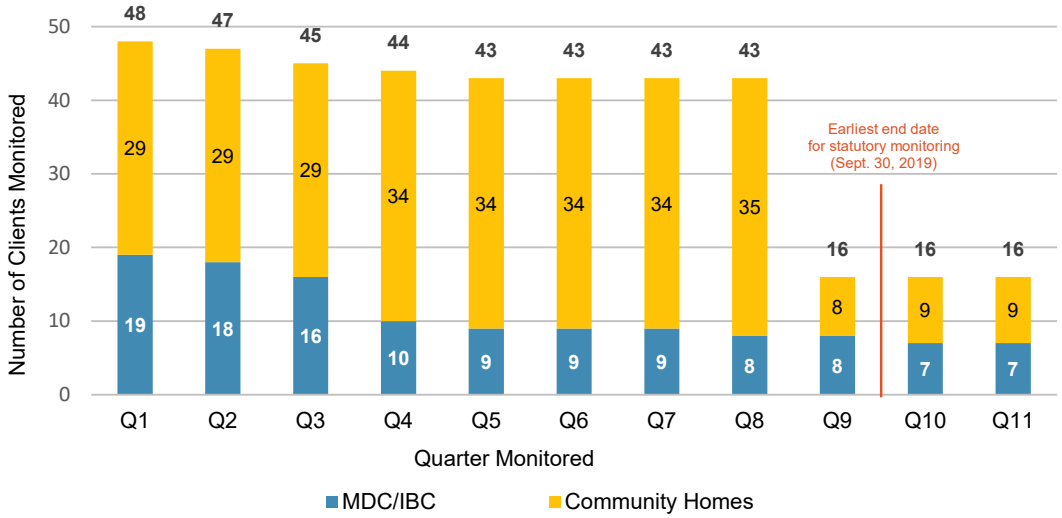
While the department did fulfill most closure requirements, two were not met. For example, the legislature mandated the department transition most clients out of MDC and into community-based services by December 31, 2016. After examining client census data, we determined 35 individuals, or 66 percent of the entire cohort, left the facility by that date.

However, in examining their placements, 26 of those 35 individuals who transitioned by December 3, 2016, or 49 percent of the cohort, entered community-based services, per statute. While 49 percent does not meet the threshold of the dictionary definition of "most," or majority (used in lieu of an available statutory definition), meeting this requirement was not fully within the department's control. For example, some individuals at MDC without active commitments chose to depart the facility without enrolling in community-based services. However, we found the department engaged in a good-faith effort to transition clients to community-based services. The other statutory requirement the department did not meet is discussed in the following section.

Department Monitored Some Clients for Incorrect Time Frame

The 2017 Legislature mandated the department monitor quarterly clients residing at MDC and those who transitioned to community homes during the closure period. Once in community homes, clients are monitored for two years. Clients who did not transition out of Boulder to community homes were not monitored. A total of 48 individuals fell under the statutory monitoring requirements. Figure 3 (see page 14) shows the clients monitored each quarter. Each quarter is broken out by whether the client was at MDC or in their community homes.

Figure 3
Twenty-Seven Clients Were Not Monitored After June 30, 2019 (Q8)



Source: Compiled by Legislative Audit Division staff based on department data.

Between Quarter 8 and Quarter 9, the client monitoring population decreased by 27 clients. We determined 26 of these 27 individuals were erroneously removed from the monitoring population and should have been monitored through Quarter 9.

One individual was removed a quarter early due to a data entry error. For the other 25, we found the two-year time frame during which they were monitored did not align with statutory requirements. Because the department began monitoring these clients one quarter earlier than required by statute, the department ended the two-year monitoring period for these 25 clients a quarter early. Monitoring for these individuals should have concluded during the quarter ending September 30, 2019 (Quarter 9). Because the actual monitoring end date for these clients has elapsed and they were monitored for a full two years, we do not make any recommendations to the department in this regard.

Department Does Not Report Monitoring Results to Family and Guardians

By requiring the monitoring of certain MDC clients who were at the facility during the closure period, the legislature intended the department to measure and report on clients' skills, abilities, and behaviors. Statute defined five specific areas to be monitored for each client. These five areas are measured by the department using standardized assessment scores and incident reports submitted during the monitoring quarter.

In addition to monitoring some of the clients' specific skills, abilities, and behaviors, the monitoring statute also requires the department to report client monitoring results:

- At least quarterly to family members and guardians who are authorized to receive health care information, and
- Annually in an aggregate fashion to the Children, Families, Health and Human Services Interim Committee (interim committee).

We found the department has reported annually to the interim committee. However, the department did not provide monitoring results to family members and guardians authorized to receive that information. As a result, applicable families and guardians of the 48 clients who fell under the reporting requirement did not receive the individual's monitoring results. Without access, they did not have the opportunity to determine whether changes in the measurement of their skills, abilities, or behaviors have occurred, as intended by the legislature. The department has since implemented procedures to notify eligible families and guardians and submitted retroactive monitoring information to them.

Department Explained Statutory Noncompliance Was an Administrative Oversight

Department management suggested not informing families and guardians of clients' monitoring data was an administrative oversight. They have since developed a process to report the results as required to family members and guardians. Further, the department explained that families and guardians can opt into receiving or accessing other information to assess a client's status, including:

- Daily notes from community providers or IBC staff,
- Participating in the client's annual plan of care meetings, and
- Notifications of critical incidents involving the individual.

While families and guardians may have had access to other data to understand how the client they support was doing, the legislature intended eligible families and guardians to receive monitoring results. Without providing monitoring results to families, the department was not complying with the legislature's intent that families and guardians have the chance to determine whether the clients they support are experiencing any changes in the skills, abilities, or behaviors measured via monitoring.

Recommendation #1

We recommend the Department of Public Health and Human Services continue to adhere to state law by maintaining a process to report clients' monitoring results to guardians and family members authorized to receive the information.

Department's Closure Plan Was Not Fully Implemented

Statute required that the department develop and implement a plan to close MDC in conjunction with the MDC Transition Planning Advisory Council. The council, at its February 2016 meeting, requested the department develop a plan to present to the council for review and approval. This request originated from membership's belief they did not have the expertise to do so themselves. The plan developed by the department was presented to the council in April 2016. It described in broad terms the department's closure achievements to date and planned future closure strategies, including:

- Keeping ASU operational as a placement of last resort for individuals in crisis,
- Building state-run group homes,
- Applying for a new Medicaid waiver, and
- Funding trainings for local law enforcement and community service providers.

The council approved the closure plan via a passed motion. Several of the plan strategies described above were implemented, including a one-time disability awareness training for law enforcement officers and first responders in Helena. However, developing state-run group homes and implementing a second waiver did not happen. Department management indicated these strategies were ultimately unrealistic from a financial standpoint.

Other States Typically Develop Detailed Closure Plans Prior to Closure Activities

We reviewed written state-run developmental center closure plans from three states that published them for public review: Louisiana, New Jersey, and California. The similar characteristics noted across them include:

- Major closure focus areas (e.g., transitioning clients, workforce management, facility repurposing),

- Specific closure actions already taken and to be taken,
- A timeline for completion of closure actions, and
- Specific benchmarks against which to measure success.

For example, New Jersey's blueprint for closing two developmental centers incorporated census reduction projections by fiscal year. California's closure plan included a section listing the activities necessary to achieve closure and their estimated dates of completion. Louisiana's plan included defining parties responsible and a benchmark measure of success, as well as a corresponding timeline for consolidating and identifying alternative use for state-run developmental centers. While the department's plan held some of these common characteristics, it did not outline the steps necessary to accomplish the strategies it proposed or had in progress, nor did it include a timeline for completion or benchmarks against which to measure successful implementation.

In our research of best practices of other states, we also noted that several states executed closure studies or developed plans prior to implementing the closure process in order to ensure full preparedness and facilitate early stakeholder participation. California statute requires detailed developmental center closure plans be submitted to the legislature for approval prior to beginning closure activities. New Jersey's legislature established a task force to perform a comprehensive evaluation of the state-run developmental centers and provide binding closure recommendations based on its findings.

MDC Transition Planning Advisory Council Did Not Fulfill All Statutory Expectations

The 2015 Legislature established a 15-person temporary planning committee called the MDC Transition Planning Advisory Council (council). The 15-person council was statutorily charged with providing closure recommendations to the department. Further, statute required the department provide the council information and staff support needed to accomplish its responsibilities. While the department fulfilled its responsibilities to the council, including providing multiple informational presentations at meetings, doing so drew department staff and resources away from transitioning MDC clients and implementing closure activities.

To learn about the council's role in the closure and whether it fulfilled its advisory tasks, we reviewed archived meeting recordings and meeting materials, and interviewed department staff and former council members. We identified several barriers that prevented the council from fulfilling all its advisory tasks. Table 3 (see page 18) outlines all the council's statutory tasks and our determinations regarding their fulfillment.

Table 3
MDC Transition Planning Advisory Council Fulfilled Half of Its Statutory Requirements

Council Responsibility	Satisfied?	Notes
Design and recommend a closure plan.	✗ No	Department developed a plan at council's request.
Propose a rate structure for providers of community-based services.	✗ No	
Identify funding sources for the proposed rate structure.	✓ Yes	
Recommend community-based services necessary for MDC's closure.	✓ Yes	
Identify repurposing options for MDC campus.	✗ No	Council motioned to support repurposing but did not identify options.
Recommend MDC workforce planning and transition options.	✗ No	Department addressed due to timelines.
Recommend secure facilities necessary for MDC's closure.	✓ Yes	
Meet at least quarterly and disband no later than June 30, 2017.	✓ Yes	

Source: Compiled by Legislative Audit Division staff based on council archives and interviews.

We identified several barriers the council experienced in addressing its statutory responsibilities, described below.

- **Concurrent and compressed timelines:** The council believed the legislature's timeline for both the closure and its tenure were unrealistic. Further, because the council's timeline and the closure timeline were concurrent, the department acted on some areas within the council's advisory purview, such as workforce management, prior to the council's ability to make recommendations in order to stay on track in meeting the closure deadline.
- **Varying levels of technical expertise among members:** Members acknowledged and were concerned about the varying levels of expertise related to the areas on which it was tasked to give recommendations. Department staff indicated that efforts to educate the members, while successful, took up a portion of the council's limited meeting time. This, in turn, decreased time available to discuss and deliberate on topics.
- **Council's responsibilities and limitations:** Members acknowledged the council's structure, scope, and authority were not always clear. Further, the council's statutory purpose was advisory in nature and the closure's responsibility was ultimately on the department. Council members sometimes struggled with the notion their role did not include oversight.

These barriers were the primary drivers behind the council's failure to meet all its statutory obligations. The department and council members indicated the larger discussion surrounding the state's developmental disabilities service system was a positive result from the council. However, it was unrealistic to expect the council to develop and establish consensus on closure recommendations at the same time the department was expected to be implementing closure activities.

Conclusion

The legislature's closure mandate required the department simultaneously plan and implement MDC's closure, necessitating it prioritize limited resources to meet an accelerated closure deadline. Planning the closure prior to its commencement, as some other states have done, could have increased the council's effectiveness and resulted in a more streamlined closure process for the department.

Department Has Not Developed a Boulder Campus Repurposing Plan

Statute charged the MDC Transition Planning Advisory Council with identifying repurposing options for the MDC campus. While the council motioned to support repurposing, it did not provide formal recommendations to the department. During the October 2015 council meeting, department and executive branch administration reported they had begun working to obtain deed and land parcel information to initiate the repurposing process. The department's closure plan indicated it would continue ongoing repurposing conversations. The department, however, did not develop a formal plan for repurposing the facility nor incorporate such details as part of its overall closure plan.

MDC Facilities Idle Since October 2018

The Boulder campus consists of 52 acres with at least 20 buildings. The secure IBC facility uses three residential units and two administrative buildings. Also in use are two large maintenance shops and a church. The remainder of the Boulder campus grounds, including the former MDC buildings, are presently inactive apart from local sports teams using the gymnasium. The department works to maintain the property's value as it sits idle.

Figure 4
MDC Residential Cottage Boarded Up

Source: Photo by the Legislative Audit Division.

After closing, MDC buildings were prepared for long term nonuse. For example, the six MDC residential cottages have boarded windows, as shown in Figure 4, and the pool in the recreation building has been drained. The empty buildings

undergo regular maintenance and monitoring. Table 4 captures the actual or expected expenditures for maintaining the idle MDC facility since its closure.

Table 4
Costs for Maintaining the Boulder Campus Facilities by Fiscal Year

Fiscal Year	Expenditures
2019	$1,130,068
2020	$782,186
2021 Forecasted	$660,000

Source: Compiled by Legislative Audit Division staff based on SABHRS data and department interview.

Expenditure information for FY 2021 in Table 4 is an estimated projection by the department. The department is requesting from the legislature approximately $2 million of appropriations to maintain the Boulder campus during the 2023 Biennium.

Lack of Repurposing Plan and Vacant Facilities Lead to Inefficient Use of State Resources

The idle facilities are maintained with budgetary resources that could otherwise support IBC's mission or other state operations. Instead, they maintain physical structures not currently providing value to the state (i.e., supporting state operations or generating revenue). While facility closure processes require time and investment to complete, without a plan, there exists no shared road map on how or when repurposing will be completed.

Identifying parties responsible, timelines, and expected outcomes as part of a plan may help provide more structured guidance to staff working on repurposing. This is important, as the department indicated several logistical decision points have yet to be made. The final repurposing decisions will likely involve parties beyond the IBC and DSD, including the department's director and executive branch administration. Implementing a formal plan would help clarify participants' roles.

Developing a formal repurposing plan would increase transparency. Some stakeholders have been and continue to be interested and invested in the repurposing efforts. Developing a formal repurposing plan may help stakeholders better understand the status of repurposing or know who is responsible for decision making.

Other States Addressed Repurposing in Their Formal Closure Plans

Other states incorporated repurposing efforts in their written closure plans. For example, Louisiana included an objective focusing on developing alternate uses of closed or downsized developmental center campuses. The plan defined the specific actions required to achieve the objective and their accompanying timelines and parties responsible. New Jersey's plans also addressed repurposing, including an analysis of

other states' reuse trends and meeting with the state economic development authority, and researching local, county, and state repurposing options to provide to the state agency responsible for property disposition.

Closure Priorities and Process Complications Extend Repurposing Efforts

Repurposing the facility was a secondary focus for the department during the MDC closure process, as they had to manage several more immediate closure activities (e.g., managing and retaining its workforce) alongside its top priority of ensuring clients safely transitioned and remained in the community. Complications identifying and unraveling land parcels and deeds, and the cross-agency work that entailed, delayed progress and decision-making points related to repurposing immediately after MDC's closure. However, this aspect of work culminated in October 2020. Department management reported it is nearing completion of its efforts to inventory, repurpose, or dispose of MDC surplus assets. Now that the closure occurred, the IBC facility has organizationally stabilized, land ownership resolutions have occurred, and surplus asset management is nearly completed, the department should develop a path towards completing repurposing efforts.

RECOMMENDATION #2

We recommend the Department of Public Health and Human Services develop a repurposing plan for the MDC facility that identifies key information, such as action steps, timelines, benchmarks to measure completion, and parties responsible for each step.

Chapter III – Status of Former MDC Clients

Introduction

Attaining successful long-term community placements for the Montana Developmental Center (MDC) clients was a concern of stakeholders during and after MDC's closure and a primary focus of the Department of Public Health and Human Services (department) during the closure. As such, we examined the MDC client closure transition process, including confirming the placements into which clients entered and determining where the clients are now. We found that most clients who transitioned out of MDC during the closure have remained in the same type of placement since. In addition, a transition file review suggested it was a complex process complicated by the hectic organizational environment created by the pending closure.

Some parents and guardians of MDC clients were outspoken during both MDC closure legislative deliberation and during the closure process. They expressed differing opinions on the closure; some were strong proponents, while others urged that the institution remain open. Regardless of their stance, they advocated for those residing at MDC, many of whom may not have been able to provide voices for themselves and all of whom belong to a historically marginalized group of individuals.

Because of this, it was important to include in our work the opportunity to hear from MDC clients themselves and learn about their perspectives and experiences related to MDC and its closure. We developed two surveys to hear from cohort clients and their natural supports. Clients indicated they are generally happy and feel safe where they live, and natural supports generally agree that community providers contribute positively to the client's quality of life. More information about client transition situations and our survey results, as well as our associated conclusions, follow in the rest of this chapter.

Most MDC Clients Transitioned to Community-Based Placements

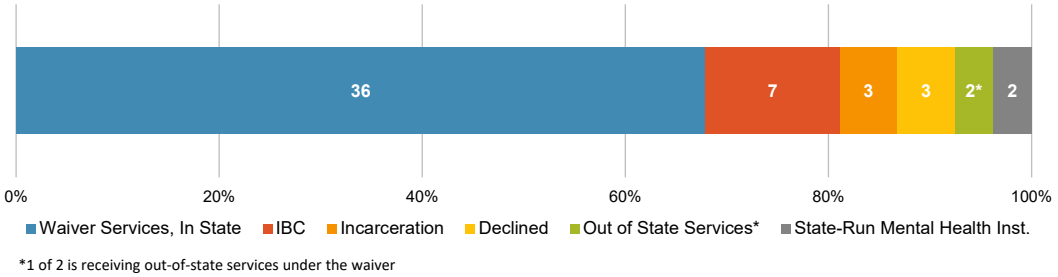
As part of audit work, we examined the transition process used by the department to secure new placements for MDC clients. Prior to doing so, however, we spent time understanding where the 53 clients from the cohort transitioned to as a result of the closure. The following section summarizes the placements for the 53 clients when they left MDC, as well as their current placements.

Many former MDC clients are now served in the community under the state's 1915(c) Home and Community-Based Services Medicaid Waiver for individuals

with intellectual/developmental disabilities (waiver). The goal of the waiver is help individuals with developmental disabilities maintain lower levels of care (i.e., reside in the community rather than an institution). Waiver services provided are tailored to individuals' assessed needs.

Individuals at MDC during the closure period transitioned to various places and services. The following figure breaks out these clients' transition types during the closure. Transition types defined here are based on the type of services or institutions, if any, to which the client transitioned. The three individuals with the placement type of Declined were at MDC on a voluntary basis and opted not to receive waiver services upon leaving.

Figure 5
Sixty-Eight Percent of Cohort Transitioned to Waiver Services With In-State Providers



*1 of 2 is receiving out-of-state services under the waiver

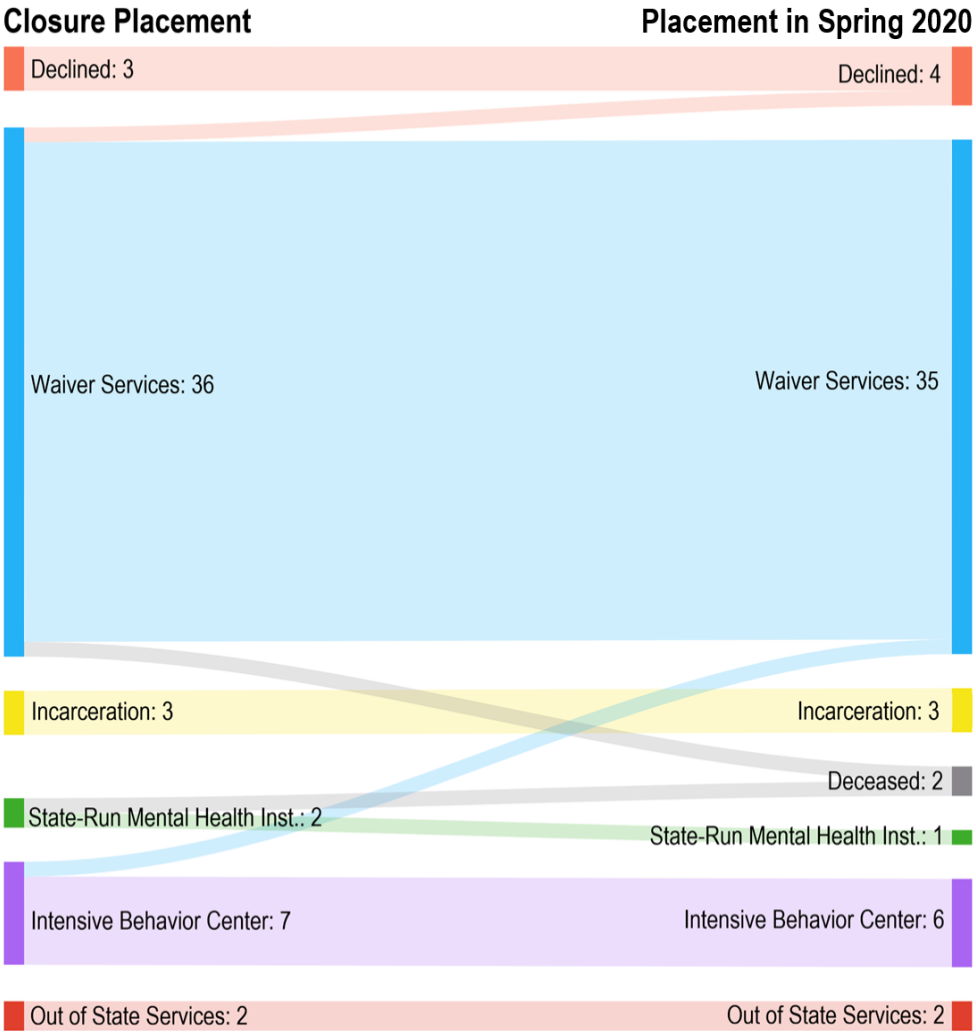
Source: Compiled by Legislative Audit Division staff based on department data and interviews.

As demonstrated in the figure, 36 of the 53 clients moved to communities in Montana to receive provider services under the waiver upon leaving MDC. Seven clients remained on the Boulder campus, as they were committed to the IBC. Two other clients were committed to state-run mental health institutions. Two individuals transitioned to receiving services from providers in other states; services for one of those two individuals are funded through the waiver. Three individuals were incarcerated.

In addition to identifying the transition situations of the 53 clients during the MDC closure process, we also examined the extent to which clients have changed placement types since their initial transition from the facility. This work entailed combining MDC and Developmental Disabilities Program (DDP) client transition and waiver enrollment information with a review of current client information available in the electronic care management system used by the department and community service providers. We also interviewed DDP staff to gain further insight into some clients' unique situations. From this work we were able to gain a better understanding of both their original transition situations and where the clients are now.

The left-hand side of the following figure groups the 53 cohort clients by their initial transition situation from MDC discussed previously. For example, 36 clients transitioned from MDC during the closure to receiving waiver services in Montana. Seven clients transitioned to IBC. The right-hand column of the figure outlines the current placement types for the 53 individuals; the arrows connecting the two columns represent a subsequent change in a client's situation from their original closure placement, in that individuals moved from one placement type to another since their initial transition from MDC. For example, one client of the seven who transitioned to IBC during MDC's closure has since been discharged and entered waiver services.

Figure 6
Most MDC Closure Client Placement Types Have Remained Stable



Source: Compiled by Legislative Audit Division staff based on department data and interviews.

One of the primary concerns resulting from MDC's closure was whether community providers would be able to adequately serve these individuals given they had a high

level of service support needs; some stakeholders worried community placements would not be successful long-term. However, the preceding figure shows that nearly all individuals who entered waiver services upon discharging from MDC remain enrolled. Most of these clients receive residential habilitation services, which includes services provided in community home settings. Others receive supported living services in their own residence or only nonresidential services. One client receiving in-state waiver services is doing so under the self-directed option, in which clients or a family member manages their services and individual plan budget. Two former MDC cohort clients are receiving services from providers in other states. In one case, the individual is receiving services with a provider that specializes in serving individuals with a specific developmental disability. One of these two individuals receives their services under the waiver.

Overall, most client placement types have remained stable. However, the placement types in the chart do not capture provider or geographical changes of residence for those receiving waiver services. For example, several clients have decided to change community service providers while remaining on the waiver. At least three clients moved at least once between community provider homes in the same city. The department indicated this is not uncommon, as clients' preferences may change or providers may determine a different location or combination of roommates may be a more appropriate fit for an individual.

Community Transition File Review Analysis

In addition to learning about the 53 clients' placement situations, we also examined the client transition process. To do so, we reviewed transition documents from the IBC in Boulder and DDP in Helena. This review focused on 46 individuals from the group of 53: 36 individuals who transitioned to community providers under the waiver and 10 individuals who transitioned out of Boulder into other situations. The transitions for seven individuals who moved to the IBC involved a different process of being discharged from MDC and admitted to IBC.

The documents required for each client depended on their transition situation. For example, individuals who did not enroll in the waiver would not be expected to have waiver documents, such as service proposals, Waiver 5 forms, or Personal Support Plans. The documents examined as part of the file review for the group of 46 individuals described above, their purpose, and what proportion of expected files were available for review are described in Table 5 (see page 27).

Table 5
Community Provider Transition Files by Process Step

File Reviewed	Transition Step Description	Percent Available for Review
Referral File	Information packet for providers to learn more about clients.	89%
Service Proposal	Application submitted by provider hoping to serve a specific client.	89%
EICP Spreadsheet	Estimated Individual Cost Plan (EICP) for waiver services developed by DDP staff.	64%
Transition Plan Meeting Minutes	Description of transition plan developed for client.	48%
Notice of Discharge Placement Letter	Notification letter mailed to relevant parties ahead of client's placement.	61%
Discharge Summary	Official record of client's discharge from facility.	83%
Comprehensive Discharge Summary	Updated information related to client and their needs sent with client to provider.	100%
Waiver 5 Form	Form indicating client understands their Freedom of Choice, per waiver requirements.	100%
Initial Personal Support Plan	Waiver plan of care required to be developed within 30 days of client's transition to provider.	97%

Source: Compiled by Legislative Audit Division staff based on department policy and documents.

We spoke with both MDC and DDP staff to learn the reasons why certain files were not available for review. Overall, the reasons related primarily to the hectic closure environment at MDC or archiving issues. For example, MDC staff indicated completing Notice of Discharge letters fell to the wayside due to closure workloads and how quickly placements were occurring. Further, several clients' departures from MDC were sudden, so holding formal transition planning meetings were not feasible for some. Staff explained planning meetings were held in a group format, which made meeting minutes challenging to record and archive.

Community Providers Generally Complimented the Closure Transition Process

Overall, the providers we spoke with felt generally satisfied with the client transition process during the MDC closure. They felt the amount and type of information MDC provided related to prospective clients was adequate, and they appreciated opportunities to visit prospective clients in Boulder. They reported feeling as prepared as they could be to serve the clients they accepted. Some transition challenges they described included needing to navigate a challenging climate created by the impending closure and build relationships with department staff. They also indicated client families may not have always been satisfied with their service proposals as they may not have been the family's or client's first placement choice. One provider mentioned a more structured follow-up

process or other regular access to MDC clinicians post-transition would have been helpful, as they held the most historical knowledge related to clients' needs.

Conclusion

The consistency of the client transition process during MDC's closure was affected by the hectic organizational environment and the effort to transition many clients simultaneously. Regardless, providers generally felt ready to serve clients as a result of the process, and nearly all individuals who transitioned to waiver services are still enrolled.

Survey of Former MDC Clients

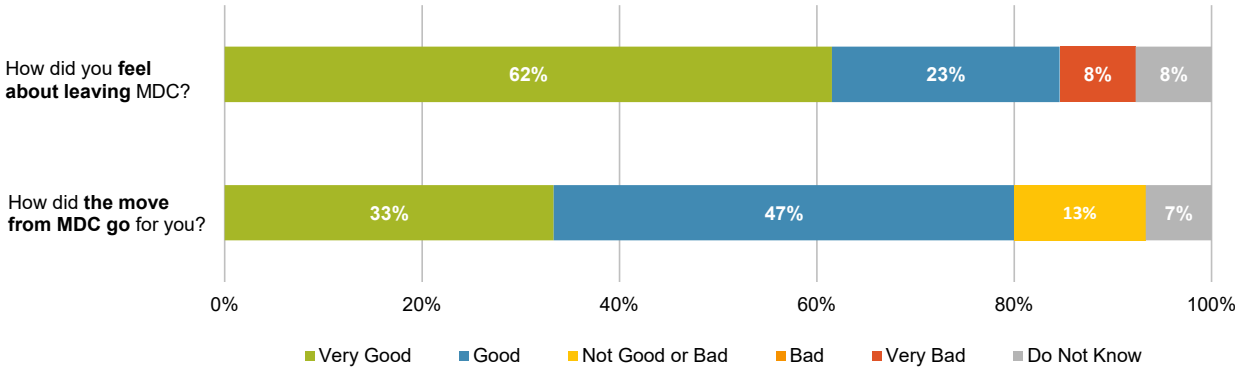
As part of our work, we prioritized obtaining the perspectives of individuals who were at MDC during the closure process to hear about their experiences transitioning out of MDC and about how they are doing now. Providing an avenue through which these individuals' voices could be heard was important, particularly as their lives were the most directly impacted by the legislature's decision to close MDC. Further, while the department administers an annual survey to each client receiving waiver services to inform care planning, we are not aware of any previous efforts to survey former MDC clients about their experiences leaving MDC due to its closure.

The client survey population consisted of 29 individuals from the audit cohort. Defining the final participant pool from the cohort was an intensive process that involved working with the subject-matter experts with whom we contracted, the department, case managers, community providers, and some client guardians. See Appendix A (see page 67) for more information on the client survey design and administration procedures. Appendix B (see page 69) contains the full set of client survey results. Overall, most clients indicated their move from MDC went well and most also feel safe and happy where they live now. Explanations respondents provided to many of the questions indicated that their friends and staff, the activities they do, as well as their privacy and level of freedom, all contribute to their happiness. The following sections outline our survey work.

Most Respondents Indicated Moving from MDC Went Well but Some Miss Friends or Staff

Many MDC clients lived at the facility for several years or longer, and MDC's closure meant finding and moving to a new home for most. Because our work involved learning about the transition process from the perspective of the department and providers, we also prioritized learning about clients' transition experiences. Our survey asked clients how they felt the move from MDC went and how they felt about leaving MDC. Responses are summarized in the following figure.

Figure 7
Most Respondents Felt Very Good or Good About Leaving MDC



Source: Compiled by Legislative Audit Division staff based on survey responses.

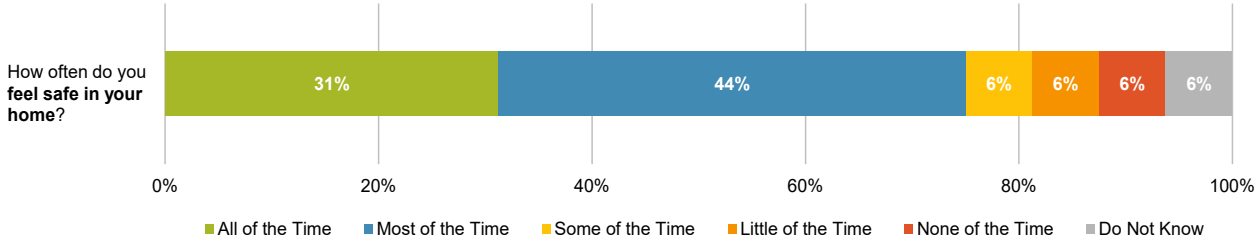
Sixty-five percent of respondents (eight individuals) indicated they felt either good or very good about leaving MDC. Three respondents indicated they felt happy to leave because they would no longer be treated poorly; however, they did not provide additional context to their explanations. While most individuals expressed positive feelings surrounding leaving MDC, several also mentioned they miss either the friends or staff they had at MDC. No participants responded that their move went bad or very bad.

Freedom, Activities, Friends, and Staff Contribute to Respondents' Feelings of Safety and Happiness

MDC's closure was mandated in part out of concerns for clients' safety and wellbeing. Further, stakeholders involved in the closure process that we spoke to expressed concern about how MDC clients impacted by the closure are doing now. As such, we asked clients a series of questions related to areas that typically contribute to a high quality of life, including safety, freedom, community and social inclusion, and happiness.

Respondents were asked how often they felt safe in their home. Seventy-five percent of individuals who responded to this question indicated they feel safe in their home either most or all of the time. The figure below provides a breakdown of responses.

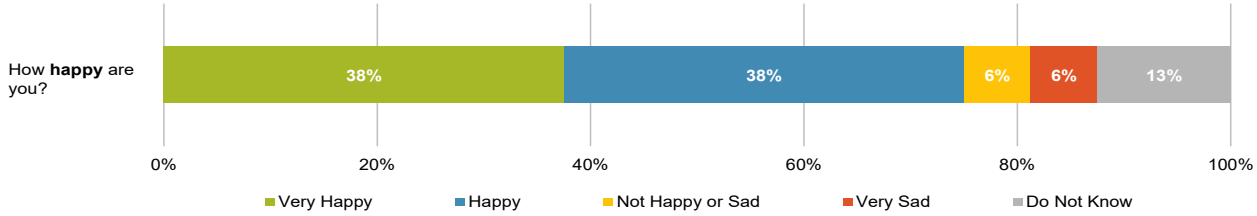
Figure 8
Most Respondents Feel Safe in Their Home All or Most of the Time



Source: Compiled by Legislative Audit Division staff based on survey responses.

The individuals who reported feeling safe in their home some, a little, or none of the time provided explanations, including: feeling concerned others were speaking poorly about them and their fellow residents, being afraid of the dark and liking to spend most of their time in their room, and worrying about being locked up, though no further context was provided for this last explanation.

Figure 9
Most Respondents Indicated They are Very Happy or Happy



Source: Compiled by Legislative Audit Division staff based on survey responses.

When asked how happy they were, most respondents indicated they felt very happy or happy. Individuals attributed their happiness to now having more freedom or privacy (e.g., having their own bedroom or bathroom). Others explained the following contribute to their current happiness:

- Living with friends and pets.
- Enjoying the food they eat.
- Doing specific activities or hobbies.
- Doing their jobs.

Explanations for responding "Not Happy or Sad" and "Very Sad" indicated their current health and desire to live closer to their family drove their responses.

We also asked participants parallel questions about both where they live now and living at MDC to identify comparative patterns between the two locations. The following table captures respondents' response combinations explaining whether they are happy where they live now and were happy at MDC.

Table 6
Most Clients Who Responded They Are Happy Where They Live Now Were Not Happy at MDC

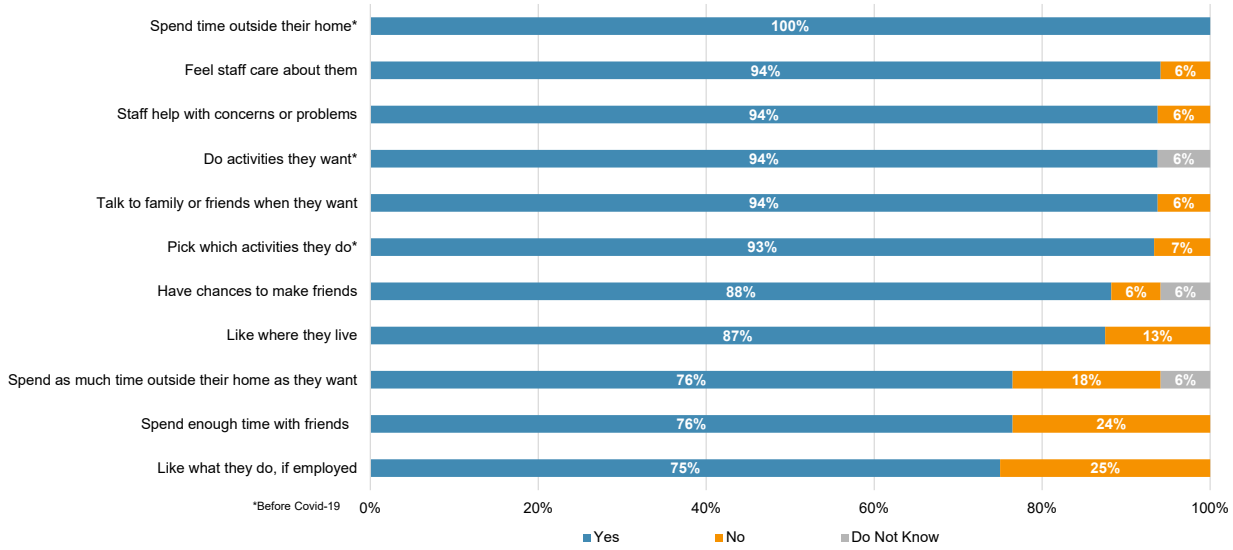
Are you happy where you live now?	Were you happy at MDC?	Response Pairs	% of Total Response Pairs
Yes	No	8	57%
Yes	Yes	2	14%
Yes	Do Not Know	1	7%
No	Yes	1	7%
Do Not Want to Say	Yes	1	7%
Do Not Want to Say	No	1	7%

Source: Compiled by Legislative Audit Division staff based on survey responses.

A total of eight respondents (57 percent) indicated "Yes" to being happy where they live now and "No" to being happy at MDC. Given that clients were committed to MDC and that the inherent differences between living in an institution and in community homes may allow for more personal choice and freedom for most living in the latter, these responses were to be expected. However, it is important to note that not all individuals felt unhappy at MDC; this theme also shone through in explanations in previous questions, particularly as they related to missing friends and staff at MDC.

We asked additional questions to learn about other facets of respondents' quality of life. Most of these questions and their responses are included in Figure 10 (see page 32). Overall, most individuals indicated they like where they live, spend enough time outside of their home and with friends, and pick and do activities they want to do.

Figure 10
Most Respondents Said Yes When Asked if They/Their…



Source: Compiled by Legislative Audit Division staff based on survey responses.

Eighty-eight percent of individuals who indicated whether they liked where they lived answered in the affirmative. Qualitative explanations as to why respondents like where they live include they:

- Have more freedom where they live now than at MDC,
- Like the house they live in,
- Like their provider staff,
- Live with and see the same friends they had at MDC, or they
- Get to do activities they like, such as shopping or bowling.

Of note, all individuals who responded to the question whether they spent time outside their home before COVID-19 indicated that they did. However, 18 percent of respondents of this question indicated they do not spend as much time outside of their home as they would like. Several gave specific reasons why they responded no:

- Sometimes weather (e.g., rain, wildfire smoke) interferes with their ability to do so, or
- While they get to do things outside of their home, they would like to do them more.

Most respondents indicated they can pick which activities they do. Another theme among individuals' responses was the availability of provider staff affecting their ability to spend time outside their home or engage in activities. Of the 12 individuals who were employed, several explained they do not like what they do because they feel their

job is stressful, they desire a job that is more integrated with the community, or want to pursue their dream job.

Survey of Natural Supports

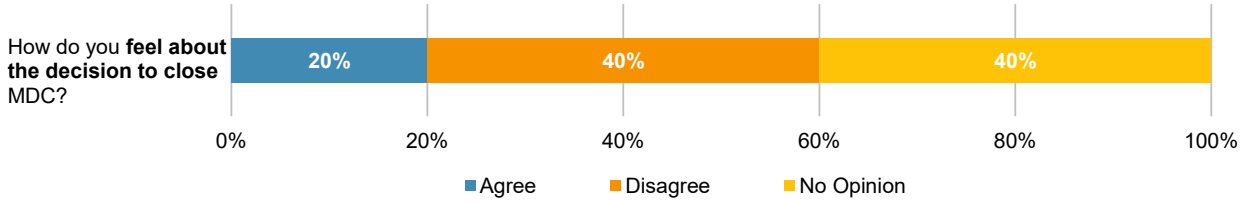
Families and guardians of MDC clients were active stakeholders during the closure who expressed varied opinions on the closure and advocated for the individuals whom they supported. As such, we also surveyed the clients' natural supports. Natural supports are family members, guardians, friends, or others in an individual's life who support or have relationships with the individual without being paid to do so. The natural supports survey was designed to thematically parallel the client survey.

The natural supports survey population consisted of 43 individuals who supported an individual from the cohort of 53. Appendix C (see page 82) contains more information on the natural supports survey design and administration procedures. Appendix D (see page 83) contains the full set of natural supports survey results. Overall, natural supports were split on whether MDC should have closed but most felt MDC staff were helpful during the transition process. Further, most generally believe community service providers positively contribute to individuals' quality of life. We noted that some natural supports' perceptions varied from clients' responses to parallel questions.

Natural Supports' Closure Opinions Vary

Client families and guardians were active stakeholders during the legislature's closure deliberation and during the closure process itself and they expressed a range of opinions on MDC's closure. As such, we asked the natural support respondents how they felt about the decision to close MDC.

Figure 11
Natural Supports' MDC Closure Opinions Vary



Source: Compiled by Legislative Audit Division staff based on survey results.

More natural supports disagreed with the closure than agreed. Two additional respondents did not choose a response, and therefore are not reflected in the table data, but provided written explanations to this question. Both individuals acknowledged MDC was the best fit for some individuals but believed there were drawbacks to the facility as well. Most individuals who disagreed with the closure stated that some

Montanans need the level of care and structure MDC provided and it served as a necessary placement of last resort. Some that agreed with the closure believe the client they support was abused or mistreated during their commitment.

Ensuring successful placements for clients was a priority of the department, and many stakeholders, including client families and guardians, were involved in the transition process. As such, we wanted to learn about natural supports' experiences during the transition process. We asked natural supports whether they had the opportunity to help choose the place the individual moved to from MDC. Responses were nearly split down the middle, with 47 percent indicating yes and 53 percent responding no. Several respondents to this question, regardless of answer, indicated there were few, if more than one, provider placement options for the individual. One respondent perceived the limited choices were, in part, due to the individual's challenging behaviors. Some of those who responded no to this question explained:

- A different natural support for the individual was the one responsible for decision-making, or
- They were never asked for input.

When asked their opinion on how helpful MDC staff were in planning the individual's transition, two-thirds reported they found MDC staff were either helpful or very helpful. One respondent believed MDC staff were not helpful and another two responded staff were a little helpful.

We also asked natural supports open-ended questions about what went well in the process of the individual moving from MDC.

- Five commented they were satisfied with the individual's placement, including one case where the individual's placement was close to family.
- Four commented that either MDC or provider staff were helpful during the process.
- Three reported satisfaction with the transition process.
- Two indicated "nothing" went well in the client transition process.

We also asked respondents what, if anything, would have improved the process of the individual moving from MDC. Five respondents expressed dissatisfaction with community providers, including:

- One believed provider staff lacked proper training to serve the individual, and
- Two believed the provider was not providing services promised during the transition process.

Further, one respondent desired a placement for the individual that was closer to their family.

Natural Supports Believe Individuals Are Generally Happy and Providers Contribute to Their Quality of Life

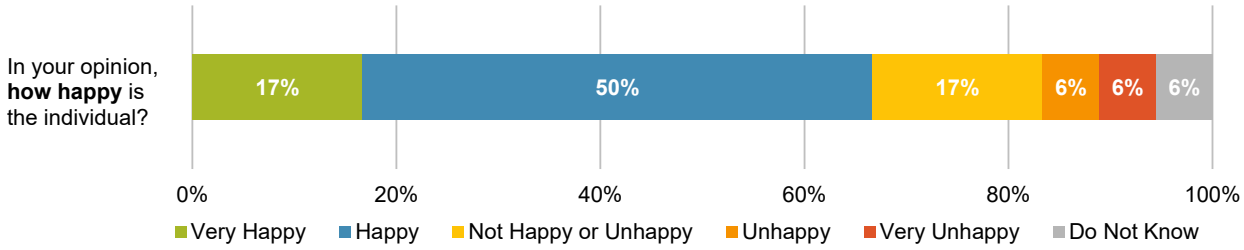
When asked their opinion on how well the individual's community provider meets the individual's needs, approximately one-third of respondents indicated the provider meets most or all of the individual's needs. Another one-third indicated at least some needs are met for the client.

Twenty-six percent indicated a few or no client needs were met by the provider. Several respondents to this question explained their concerns stem from perceived inadequate provider staffing, including that:

- Providers are understaffed, impacting clients' abilities to engage in trips outside of their home,
- Staff do not have adequate training to address challenging behaviors, and
- Providers do not have enough types of staff support (e.g., nurses).

Respondents also reported their opinions of how happy the individual is. A breakdown of natural supports' responses follows.

Figure 12
Two-Thirds of Respondents Believe the Individual Is Very Happy or Happy



Source: Compiled by Legislative Audit Division staff based on survey data.

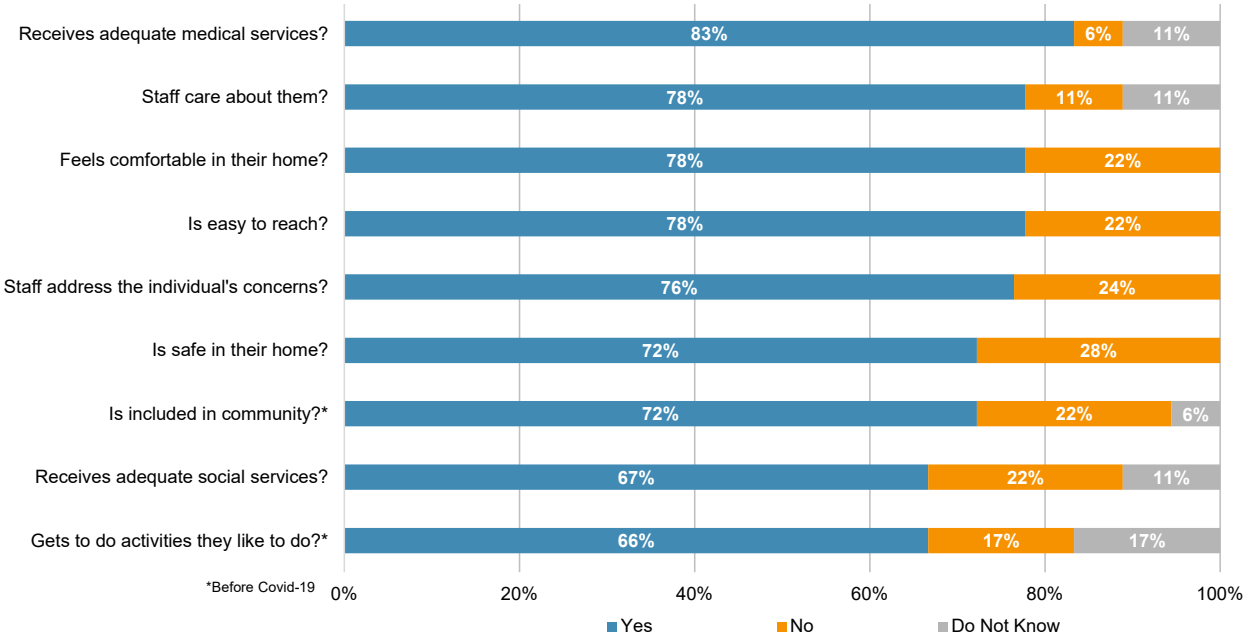
Almost 70 percent of responses indicated they perceived the individual to be happy or very happy. This percentage varied slightly from the 76 percent of clients who reported the same (see Figure 9 on page 30). Further, 17 percent of natural supports believed clients were not happy or unhappy, whereas 6 percent of clients reported they felt not happy or sad.

Natural supports respondents explained they believe the provider's services or staff were drivers behind individuals' happiness. Two respondents said they believe individuals are happy where they live except when their living situations are disrupted by other

clients' behaviors. Individuals who are believed to be unhappy or very unhappy are perceived as such because the respondents believe they would prefer to live elsewhere, including with or closer to family, or back at MDC.

As with the client survey, we asked natural supports a series of questions related to additional facets of the individual's quality of life. Most respondents answered in the affirmative to these questions, including their beliefs on the adequacy of specific services clients receive, and whether they feel safe in their home and are active in their communities. However, affirmative response percentages trended lower across similar questions for natural supports than for clients. For example, while 94 percent of clients felt their staff care about them (see Figure 10 on page 32), 78 percent of natural supports reported the same. Responses to most questions in the series are outlined in Figure 13.

Figure 13
Most Respondents Said Yes When Asked if They Believe the Individual('s)…



Source: Compiled by Legislative Audit Division staff based on survey data.

Comments for several of these questions related to inadequate provider staffing. For example, one respondent indicated the provider has not had any medical staff for an extended period. One respondent indicated the individual is not included in the community often due to insufficient staffing. For those who responded "No" to whether they can reach the individual easily, they explained the individual either has phone restrictions, the client-use telephone is disconnected and locked in a cupboard when not in use, or that no one reliably answers telephone calls. Three respondents do not believe the individual feels safe in their home due to other clients in their residence engaging in maladaptive behaviors directed towards or affecting the individual.

Conclusion

While both client and natural supports surveys indicate most individuals feel safe where they live and are happy, more clients feel positively about how they are doing now than their natural supports do. Client choice and provider staff, including available staffing levels, are perceived as contributors to clients' quality of life.

Chapter IV – Client Care and Safety

Introduction

One of the audit objectives focused on whether the Montana Developmental Center (MDC) closure has ensured safety and community inclusion outcomes for former clients. Our work examined statutory client monitoring data and Personal Support Plans (PSPs) and associated documentation for clients from the cohort receiving services under the state's 1915(c) Home and Community-Based Services Medicaid Waiver for individuals with intellectual/developmental disabilities (waiver). We also examined Individual Treatment Plans for these clients from their time at MDC, as well incident reports of abuse, neglect, exploitation/mistreatment, and injury of unknown source from both MDC and community providers for applicable clients.

We found that while the statutory monitoring assessment scores of skills and abilities declined for a few clients after they transitioned to community homes, clients' scores were generally stable once residing at a community home. We also observed there were significantly fewer incidents involving abuse, neglect, exploitation/mistreatment, or injuries of unknown source reported by community providers in our sample than at MDC. Further, we found that the Department of Public Health and Human Services (department) monitors clients and providers as part of the PSP process, but there is room for improvement in ensuring the PSP process is consistently person-centered.

We observed information was not readily available to understand how former MDC clients were doing overall without compiling information stored in different formats, systems, and physical locations. While the department does monitor the safety and outcomes of clients in its care, we determined the department could enhance its management information availability to more readily assess how former MDC clients are doing. The department's recent implementation of a new comprehensive electronic care management system may assist in doing so. This chapter provides information on the work described above and includes our associated conclusions, findings, and recommendations.

Statutory Monitoring Data Analysis

As discussed in Chapter II, statute requires the department to monitor former MDC clients during their time at the facility during the closure and for two years upon transitioning to community homes. The legislative intent of this requirement was to determine whether clients' skills, abilities, and behaviors changed as a result of transitioning to or living in community homes. The department reports aggregated monitoring data to the legislature on an annual basis.

To further address the legislature's desire to understand whether clients' skills, abilities, and behaviors changed, we completed a more in-depth analysis of the monitoring data than is statutorily required of the department. Our goal was to identify any significant changes in clients' scores over time, including on an individual level.

Statute specifies the department must monitor clients' communication skills, daily living skills, and emotional well-being. The department uses a standardized assessment to score each of the three areas, called domains. The department monitors incidents of physical aggression and sexually inappropriate behavior using clients' incident reports. Forty-eight individuals were required to be monitored by statute.

We isolated data on 26 individuals with eight quarters of community home data to determine whether they experienced changes in skills, abilities, or behaviors over their two years living in the community. We averaged each score and number of monitored incidents for each quarter; there were no significant changes or trends for the group across quarters. We also randomly selected 13 of the 26 clients and examined their individual data to ensure any trends were not obscured by averaging scores across the group. There were no significant changes for these clients.

Nine of the 48 individuals had quarterly data from both their time at MDC and community homes. We compared MDC and community home data for each to identify any post-transition changes. Below describes whether monitoring data changed for each of these nine individuals.

- **No significant changes:** Three individuals' domain scores and number of monitored incidents remained stable.
- **Decline in domain scores:** Three individuals experienced a significant decline in one or more domain scores following their MDC discharge. Their scores remained lower across their community home quarters.
- **Increase in monitored incidents:** Two individuals had an increased number of incidents of physical aggression or sexually inappropriate behaviors. One experienced increased monitored incidents over time in their community home and one experienced a spike of monitored incidents in the first quarter after transitioning from MDC.
- **Decrease in monitored incidents:** One individual showed a decrease in monitored incidents following their transition to their community home.

While this data is from a very small subpopulation of individuals, the change in pre- and post-transition monitoring data reflect that transitioning may have impacted some clients' skills, abilities, and behaviors. While the data does not capture the specific reasons these changes occurred, it does demonstrate that transitioning from MDC to community homes affected individuals differently. Further, it shows the importance of

data as a tool to understanding how clients are doing, both individually and as a group, and whether individual interventions or system-level changes are needed to maintain the highest level of client care.

MDC Incident Reporting Analysis

Per §53-20-163, MCA, allegations of mistreatment, neglect, abuse and injury of unknown source on the Boulder campus must be reported to the Department of Justice (DOJ). The DOJ must investigate each allegation that meets these definitions and complete a written investigation report of its findings. The DOJ began formal investigations of MDC incident reports per statute in April 2014.

An incident report can contain one or more allegations. Allegation types include abuse, neglect, and mistreatment. Injury of unknown source can also be indicated on an incident report. Allegations can be made against staff, other clients, or other individuals. The department defines and the DOJ investigates the following abuse types: physical, verbal, sexual, and psychological.

To help understand client safety outcomes, we completed two analyses using incident reporting data from MDC. First, we analyzed aggregated incident report data for the entire Boulder campus between 2014 and 2019 to understand facility-wide incident trends over time. This analysis follows in the next section. Second, we analyzed specific incident reports of abuse, neglect, exploitation, and injury of unknown source reported at the Boulder campus and by community providers for the 36 individuals who transitioned to waiver services during MDC's closure.

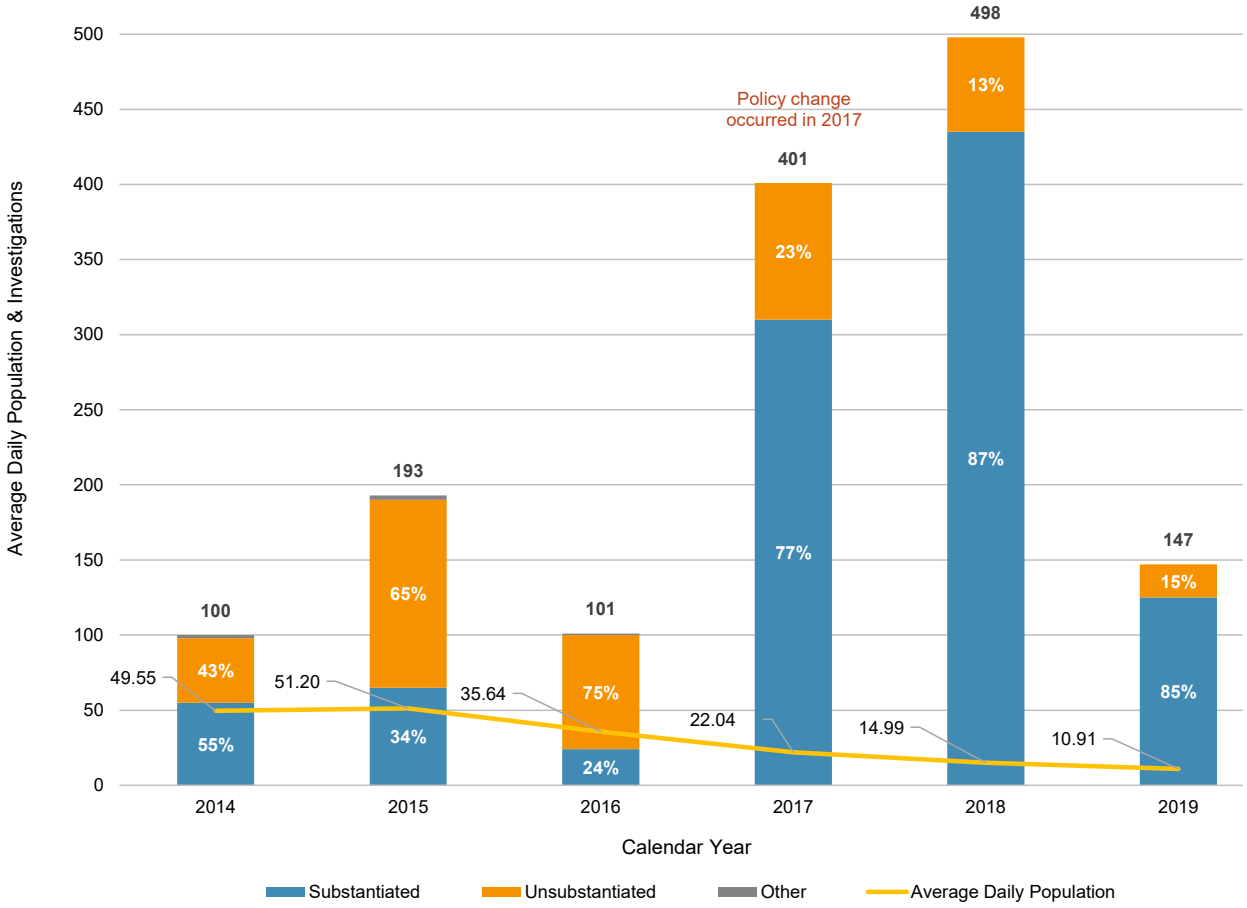
Increase in Incidents and Substantiated Allegations Due Primarily to Policy Change

We analyzed incident report trends for the entire Boulder campus facility between 2014 and 2019. This analysis included all Boulder residents over time, rather than just the 53 individuals from the cohort. The purpose of this analysis was to understand the larger trends of incident reporting and investigations at MDC and the Intensive Behavior Center (IBC) over time and in relation to the closure. Data for this analysis was compiled from DOJ's annual aggregate reports; it was not available from the department, as they have not historically maintained aggregate incident reporting data.

Following an investigation of an incident report, the DOJ substantiates or unsubstantiates each allegation. Substantiated incident reports contain at least one allegation the DOJ confirmed occurred (i.e., substantiated) based on the evidence collected. Unsubstantiated incident reports contain no allegations for which the DOJ found evidence.

Figure 14 shows the total number of investigations completed by the DOJ for calendar years 2014 through 2019 and the percentage of total incidents that were substantiated versus unsubstantiated. "Other" investigations in the figure are those that either led to an inconclusive determination from the DOJ or were still in progress at time the data was reported. Also included in the figure is the Boulder campus (i.e., both facilities) Average Daily Population (ADP) for that calendar year to demonstrate the declining census in relation to investigations over the time period.

Figure 14
Total DOJ Investigations Rose Significantly in Calendar Year 2017



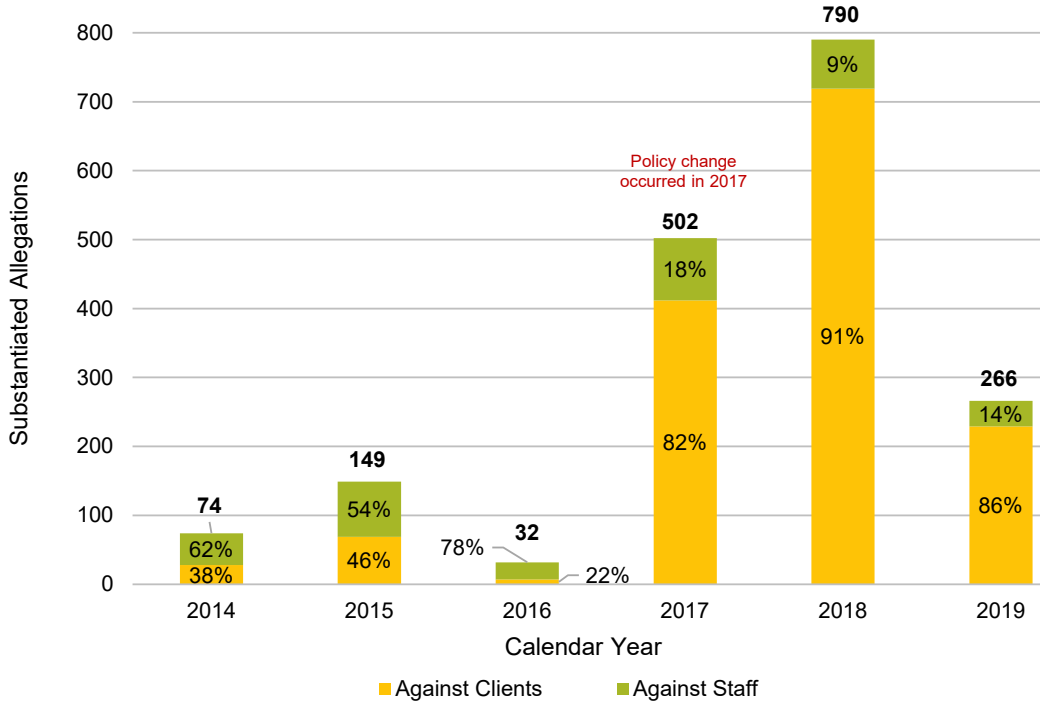
Source: Compiled by Legislative Audit staff based on department and DOJ data.

The figure shows the total number of DOJ investigations rose nearly 300 percent between 2016 and 2017. In 2019, total investigations decreased, likely as a result of MDC's closure and IBC's low census; however, the proportion of 2019's total incidents that were substantiated remained higher than prior to 2017, as does the percentage of total investigations that were substantiated.

We also examined the total number of DOJ substantiated allegations across all incidents per calendar year. Incidents can contain more than one allegation and allegations

can be made against clients or staff. The figure below shows the total substantiated allegations and the proportion of substantiated allegations made against clients or staff for calendar years 2014 through 2019.

Figure 15
Annual Substantiated Allegations Against Clients Rose Significantly in 2017



Source: Compiled by Legislative Audit Division staff based on DOJ data.

The yellow portion of each bar demonstrates the proportion of substantiated allegations made against clients. The green portion shows the proportion of each year's substantiated allegations made against staff. Prior to 2017, each year's proportion of allegations substantiated against staff was higher than those against clients. After 2016, most substantiated allegations were against clients.

We interviewed department and DOJ staff to determine why substantiated allegations against clients increased significantly beginning in 2017. We determined these shifts were attributable to a June 2017 policy change that altered the types of incidents reported to and investigated by the DOJ. This change originated from a survey of MDC by the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS). CMS determined not all client-to-client abuse allegations were being investigated by the DOJ. According to the DOJ, prior to the policy change, client-to-client abuse allegations that did not result in obvious harm or injury, per incident descriptions submitted by MDC, were typically not investigated unless they

involved potential neglect allegations. CMS required the DOJ investigate every client-to-client abuse allegation submitted, regardless of whether DOJ determined it met the definitional threshold of abuse. The CMS survey and subsequent policy change was the primary driver of the large increase in investigations and substantiations of client-to-client abuse allegations.

Department Does Not Coordinate With DOJ on Incident Reporting Changes Over Time

In examining incident report trends, we determined changes in the organizational policy environment significantly impacted the data and how trends could be interpreted. To determine the cause of data trends we observed, we learned from the department and DOJ that what incidents that MDC reports to DOJ and what DOJ investigates and substantiates evolved over time. Information regarding these policy or procedural changes was not reliably available and the parties did not share a consistent understanding of incidents reported, including how and why some incident reporting policies and procedures were developed and when changes occurred.

Lack of Coordination Impacts Ability to Interpret Incident Data

Changes in incident reporting policies or procedures over time may be expected and appropriate, as was the case in 2017 when investigatory practices changed to respond to CMS survey findings. However, such changes can affect how incident data must be interpreted and reported to stakeholders. Without coordination between the DOJ and MDC in maintaining a formal, shared understanding of incident reporting processes and changes, stakeholders' ability to accurately interpret incident data over time is diminished. This, in turn, may jeopardize accurately assessing the safety of clients.

Consistently maintaining information that provides context to accurately interpret data over time also allows for greater transparency and credibility, both of which were the legislative intent behind requiring DOJ to act as a third-party investigator for MDC/IBC incidents. Without shared coordination in recording mutual agreements and procedures, detecting any procedural inconsistencies of one party may not be possible for the other. Further, staff turnover at either agency could result in a loss of historical institutional knowledge critical for maintaining process consistency.

Incident Reporting Process Evolved but Formal Agreement Never Developed

The DOJ began investigating MDC/IBC incident allegations of abuse, neglect, mistreatment and injuries of unknown source in the spring of 2014 as a result of

legislative action during the 2013 Legislative Session. As a result, the department and DOJ worked together extensively to develop processes and policies to operationalize the 2013 statutory mandate.

However, as MDC and DOJ established and refined the incident reporting system, they never developed a formal agreement or process that defines and maintains a consistent, reliable record of changes in key procedures either party engages in as part of the system. By speaking to staff of both parties, we determined some practices taken for granted were not written down; for example, the DOJ uses the MDC policy manual's incident definitions to make the determination whether the allegation meets the definitional threshold for the types of incidents it is statutorily required to investigate. This decision point is not currently documented, though DOJ indicated it is in the process of developing its own policy manual.

Best Practices Surrounding Intra-Agency Controls Include Formal Documentation

State policy recommends the establishment of internal control activities to minimize risks and ensure an entity's objectives are achieved in an effective and efficient manner. These control activities should include ensuring the identification, capture, and exchange of information both within the agency and with external parties. It is reasonable that such controls, including the creation and maintenance of documentation of processes and any subsequent changes, would include activities that span programs or agencies.

Federal standards on inter-agency processes include developing a formal written agreement summarizing activities, roles and responsibilities of parties involved, and establishing compatible policies and procedures for operating across agency boundaries. These agreements should be regularly monitored and updated, as appropriate. Further, we found agencies that serve individuals with developmental disabilities in other states have developed formal documentation with other agencies involved in their incident reporting and investigation processes. For example, multiple Massachusetts agencies have a written framework describing each party's responsibilities in the process of identifying, reporting, investigating, and prosecuting crimes against victims who have disabilities. Further, a national association for state developmental disability professionals acknowledges memoranda of understanding between partner agencies help strengthen incident reporting systems.

Implementing these best practices would help strengthen the incident reporting system at IBC, including ensuring a shared understanding between the department and DOJ of changes or updates made by one or both parties over time and how those changes

may affect the interpretation of incident reporting data for management information or stakeholder reporting purposes.

RECOMMENDATION #3

We recommend that the Department of Public Health and Human Services work with the Department of Justice to develop and maintain a memorandum of understanding that defines agency and staff roles, expectations, and processes for IBC incident reporting.

MDC and Community Provider Incident Report Analysis

Community providers supporting clients via services funded by the waiver are required to report client incidents to the department and other relevant parties. This system is separate from the MDC/IBC incident reporting system. We examined DOJ investigation reports at MDC and equivalent incidents reported by community providers for 36 individuals who enrolled in waiver services upon discharging from MDC. Individuals from the cohort who did not transition to waiver services would not have community incident reports and were therefore were not included in this examination. The purpose of this work was to compare incidents for clients during their time in both settings and to make conclusions regarding clients' safety before and after their transition to the community.

The department defines community provider reporting requirements. Community incidents are classified by type (e.g., injury, medication error, altercation) and categorized as critical, reportable, or internal incidents depending on the extent to which the client's safety is compromised. Incidents suspected to involve abuse, neglect, or exploitation are classified as critical incidents. All critical incidents are investigated in accordance with Developmental Disabilities Program Incident Management policy.

MDC and Community Provider Incident Comparison Analysis

The incident reporting system at MDC/IBC is a separate system from the community incident reporting system. As such, we had to consider differences between the systems as part of our review.

For MDC/IBC, the DOJ is required to investigate reported incidents of abuse, neglect, mistreatment, or injury of unknown source. While mistreatment is not defined within the community incident reporting system, exploitation is. MDC/IBC's mistreatment

definition incorporates any type of exploitation. As such, we examined community provider incidents labelled as exploitation.

While injuries must be reported by community providers, the reporting system does not delineate those that are from an unknown source. However, community providers must label any incident as abuse if injuries from an unknown source are suspected to be a result of abuse. As such, our examination of community incidents reports involving abuse captures as equitable of a comparison as possible between the two systems in this regard.

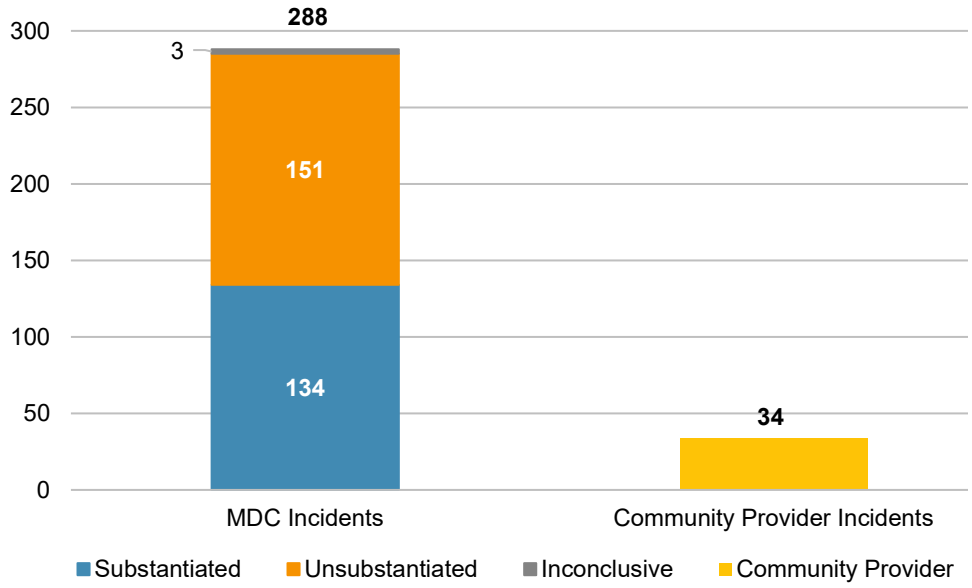
MDC/IBC abuse definitions are more expansive than those used by the community incident reporting system to incorporate statutory and federal definitions and address the more rigorous reporting expectations placed on the institution. For example, the MDC/IBC system defines a psychological abuse as a separate reporting type, whereas the community incident reporting system incorporates "mental injury" as a part of its abuse definition. Therefore, one limitation of this examination is that MDC/IBC incident report data defines a wider swath of incident types, particularly those involving abuse, given the more rigorous standards they must maintain.

Given the differences between the two incident reporting systems described above, we made efforts to ensure as equal a comparison as possible between the MDC and community provider incidents. First, we isolated community provider incidents from our identified population involving suspected neglect, exploitation, and abuse in order to ensure community incident types were comparable to MDC incidents. This was to compensate for community providers having to report a wide range of incidents beyond just abuse, neglect, or exploitation. Second, we isolated and compared MDC incidents and community incidents that occurred within two years of the client's discharge. For example, we examined the MDC incident reports dated within the two-year period before the client's discharge and examined community incident reports for clients dated within two years after the client's discharge from MDC.

More Incidents Reported at MDC Than at Community Providers

Our examination looked at total incidents for all clients for each time frame. For MDC, we compiled all incident reports for each clients' two-year period preceding their discharge; that data is shown in the left bar of Figure 16 (see page 48). The MDC incidents are broken down by whether they were substantiated by the DOJ. Three incidents at MDC were classified as inconclusive. The right bar of Figure 16 represents the total number of community provider incidents reported as involving abuse, neglect, or exploitation within the two-year periods after clients discharged from MDC.

Figure 16
MDC Incidents Investigated by DOJ Significantly Higher Than Community Provider Incidents Reported During Time Frames Analyzed



Source: Compiled by Legislative Audit Division staff based on department and community provider data.

As illustrated by the figure, there were 288 total MDC incidents of suspected abuse, neglect, exploitation, or injuries of unknown source reported within the sample we examined. Investigation forms and administrative reviews indicating whether community incidents were confirmed to have occurred are housed separately from the incident data extracted for this analysis and were not incorporated as part of this work.

One reason there were significantly more substantiated incidents at MDC than incident reports for community providers is due to more rigorous incident reporting definitions and expectations at MDC and IBC than in the community. Inherent differences between the community and institutional environments may also play a role, including the following factors:

- There are fewer clients living together and interacting in community provider settings.
- Community providers choose whom to serve and have more control over which clients live or work together.
- Due to the nature of the facilities, clients committed to MDC/IBC typically have more volatile behaviors.
- Clients in community provider settings likely have more choice and control over more aspects of their life.

Trend of Increased Incidents for Some Clients Close to Discharge

Our work also included examining the frequency of incidents in relation to each client's discharge dates. An anecdotal assertion made during the closure was the organizational instability and uncertainty experienced at MDC during its closure contributed to an increase in client dysregulation and maladaptive behaviors, which can be precursors to reportable incidents.

For 30 of the 36 clients, there was no evidence of an increase in substantiated incidents as they approached their discharge date. However, for six of the individuals, we noted an increase in substantiated incidents within six months of their discharge date. These six individuals all discharged after the June 2017 policy change that required all client-to-client incidents to be investigated by the DOJ, which led to an increase in the number of total incidents investigated compared to before the change.

Most of the incidents for these six clients prior to discharge (and that occurred after June 2017) were client-to-client in nature. As such, the increase in substantiated incidents for these individuals may have been influenced by this policy change. However, the department did suggest increase in incidents close to a client's discharge would be expected for some individuals, as environmental disruptions can contribute to dysregulation and maladaptive behaviors for some.

Conclusion

Differences between the two systems, including that MDC/IBC is held to higher reporting expectations, impact the ability to use incident reports as a proxy for measuring client safety across each setting. While the number of investigated incidents at MDC were significantly higher than community incidents suspected to involve abuse, neglect, or exploitation, there are several limitations that prevent us from concluding the difference is solely because the community is a safer environment for the individual than the institution.

Personal Support Plans: Waiver Plan of Care Analysis

Case managers ensure clients enrolled in the waiver receive the services they need and are safe and healthy in the community. Case managers interface with both clients and their community service providers to ensure clients are doing well and providers are supporting clients' needs. These responsibilities include managing the client's waiver plan of care that outlines the client's life goals and steps they and their supports, primarily their community provider, will take to help reach these goals. They are also a member of the client's care team, which also includes the client, their service provider(s)

and legal guardian(s), as well as any other person the client wants to invite. The team may also include staff from the Developmental Disabilities Program (DDP).

Client plans of care, called Personal Support Plans (PSPs), are developed annually by the care team in a consensus-based process. They are required by federal regulations, state statute, and administrative rules. PSPs identify supports and services necessary for an individual to achieve independence, dignity, and personal fulfillment and are person-centered. Person-centered means plans are individualized to the person's wants and assessed needs and focus on the individual rather than the services the provider delivers. Based on administrative rules and department policies and procedures, PSPs must describe a client's life goals and how they will achieve them by developing:

- Vision statements (visions) describing what the client wants to achieve in the long-term.
- Outcome statements (outcomes) outlining what the client wants to accomplish during the upcoming plan year. They must support achieving their vision.
- Action statements (actions) establishing how the client will achieve their outcomes. They are activities to be completed by the individual and must be framed as such.

Administrative rules also require community providers complete quarterly reports during the plan year that describe the individual's progress in completing each PSP action.

PSPs Not Consistently Maintained or Person-Centered

We reviewed clients' most recently completed PSPs and corresponding quarterly reports for the 38 clients who received waiver services at any point since discharging from MDC. While all PSPs were present for review and contained visions, outcomes, and actions, we found that PSPs are not consistently developed and maintained by the department in a manner that reflects a person-centered approach.

We reviewed 558 PSP actions to determine whether they met the following departmental policy requirements to describe: 1) the person responsible for completing the action, 2) the frequency with which the client completes the action, 3) its purpose, and 4) whether the action was written to be completed by the client. Results of this analysis are described in Table 7.

Table 7
PSP Actions Did Not Consistently Meet Policy Requirements

Requirement	Total That Met Requirement	Percent of Total
Frequency	288	52%
Party responsible	398	71%
Purpose	141	25%
Completed by person	368	66%

Source: Compiled by Legislative Audit Division staff based on analysis of department documents.

PSP actions did not consistently meet the four policy requirements dictating how they should be written. Incorporating an action's purpose may help delineate how expectations in the PSP are tailored to the individuals' assessed needs or otherwise help them reach their outcomes and visions. Framing the action to be completed by the person may also help ensure the PSP document reflects the person-centered approach the care team is required to take, and that actions remain oriented towards what and how a client will work toward achieving or maintaining their desired life goals.

Our observations during action analysis noted that, in some cases, the individual was written as a passive recipient of services rather than the primary actor. Example of these types of actions include, "Client will receive transportation…" or "Client has funds in their individual cost plan to…" In addition, some actions we observed had an administrative orientation that did not involve the client or were one-time-only; for example, "Provider will replace the type of glass in the home…" These observations further reflect that not all PSPs are maintained or developed in a person-centered manner, as they sometimes take on an administrative purpose that focuses on what others will do for a client, rather than what the client will do. The department held a statewide training for case managers to mitigate this practice, but it is unclear if this training is ongoing.

PSP Quarterly Reports Do Not Always Capture Client Progress

Case managers are responsible for developing and maintaining the annual PSP and ensuring clients receive services necessary for achieving their PSP actions, outcomes, and visions. To aid case managers in their PSP oversight responsibilities, community providers must submit quarterly reports summarizing the client's progress towards each PSP action.

We reviewed provider quarterly reports for 37 of the 38 PSPs selected for review. One PSP was excluded because the client did not yet have a full year's PSP. We analyzed each quarterly report to determine whether the provider wrote a brief summary of client progress toward the attainment of each action, as required by administrative rule. We did not, however, verify whether the client made progress on a specific action. We took this approach because clients make their own choices whether they want to work towards most of their actions; therefore, a lack of action progress does not necessarily reflect inadequate provider support.

Of the 37 PSPs analyzed, all four quarterly reports from the PSP were present for 21 (57 percent). The other 16 PSPs were missing one or more quarterly report. Within

the 21 PSPs with all four quarterly reports available for review, 76 percent of the actions (233 of 305 total) had progress descriptions included for all four reports.

The remaining 24 percent did not include clear progress descriptions or described what provider staff did rather than describing the client's progress toward an action. For example, a description that "Client received prompts to [achieve action]" does not describe whether or to what extent the client completed the action upon receiving prompts. Other progress descriptions included references to other internal data sources that described a client's progress, rather than including it in the quarterly report itself.

Based on our review, we believe reports may be viewed as administrative. For example, several clients' quarterly reports contained verbatim progress descriptions across quarters. At least one client had specific progress description date ranges and data from a previous quarter's report included in a subsequent report and one other client had the exact same progress descriptions, verbatim, for all four quarterly report documents.

Person-Centered Approach Does Not Consistently Guide PSP Development

The person-driven and person-centered nature of PSPs is not always reflected in the documents. While lack of documentation may not necessarily reflect a lack of services rendered or client progress achieved, the PSP is meant to be a guide for the client's care team in supporting the client in achieving their actions, outcomes, and vision. However, the required approach cannot be confirmed if the foundational PSP documents are not developed and recorded as such.

Providers indicated sometimes PSP visions and outcomes could be developed to be more meaningful to the client. For example, a vision may indicate the client wants to continue living in the same location; while such a vision may contribute to the client's ongoing quality of life, the provider explained that goal can still be achieved while working towards a more personalized vision. Without developing more meaningful visions or outcomes, there may be less guarantee the PSP process reflects a person-centered approach.

Department management explained that the federal requirements they must track and report to CMS on an annual basis differ from the policy requirements that we analyzed. For example, it tests a sample of PSPs each year to determine whether they address individuals' assessed needs and personal goals. While PSP quality assurance processes occur, the department acknowledged it does not evaluate whether quarterly reports are present and capture client progress, nor whether the PSP documents are written in a person-centered way.

Outdated, Decentralized PSP Requirements Not Perceived as Meaningful

Both the department and providers consider current PSP requirements antiquated and unmeaningful in ensuring clients reach their personal goals. As a result, what is required is not always done in practice. This disconnect is reflected in our observations that some PSP actions appear to fulfill administrative needs rather than client goals. The department indicated they recently implemented statewide case manager training to counter these concerns.

Providers perceive some PSP processes as duplicative or administratively burdensome. For example, compiling quarterly report data may be redundant for providers who already record and compile this information. Providers indicated manual PSP processes, such as sending paperwork back and forth with case managers, are time intensive. The department believes its forthcoming electronic care management system will alleviate this burden by automating these processes.

Further, providers described differing expectations and approaches to the PSP process across individual case managers or between DDP regions. These differences may result in inconsistencies in how PSPs are completed and managed between clients in different regions, or between providers in the same region. Implementing ongoing training across regions may help ensure a more consistent approach to the PSP process.

The department also indicated it may be challenging to meet PSP requirements, as they are decentralized across multiple sources. Per statutory requirements, the department established a workgroup focused on streamlining developmental disability administrative rules, policies, and procedures, including reviewing, updating, and consolidating PSP-related requirements. The workgroup includes service providers, case managers, and other stakeholders and is in the process of updating PSP policy, procedures, and administrative rules to ensure consistency and best practices.

RECOMMENDATION #4

We recommend the Department of Public Health and Human Services:

A. *Update and centralize policies, procedures, and/or administrative rules for Personal Support Plans to increase administrative efficiencies, ensure greater consistency, and reflect person-centered planning,*

B. *Provide ongoing, statewide training for case managers and providers regarding policies, procedures, and administrative rules, and*

C. *Monitor Personal Support Plans for adherence to requirements to help ensure ongoing person-centered planning across regions and providers.*

MDC/IBC Individual Treatment Plan Analysis

In addition to reviewing PSPs, we also analyzed clients' most recently completed Individual Treatment Plans (ITPs), which are the plans of care developed for individuals at MDC and IBC. Like PSPs, ITPs outline specific objectives determined necessary to meet clients' needs. Our original intent in examining ITPs was to compare PSPs and ITPs and their respective quarterly progress reports to make determinations regarding whether a service setting influences the extent to which clients reach their plan of care objectives.

However, we ultimately determined such a comparison was not realistic, in part because ITP quarterly reports were not developed until early 2016, affecting the number of individuals in the review population who had these documents available. Further, we also learned that ITP quarterly reports are not structured in a way that explicitly addresses progress the client made that quarter for each individual ITP objective, which are client treatment goals akin to PSP actions; as such, the data available did not allow us to reliably quantify whether each ITP objectives had a progress description present.

However, we were able to determine ITPs more consistently met their requirements in how their objectives must be written and the associated information included than did PSPs in meeting analogous action statement requirements. For this work, we focused on the 38 clients from the PSP analysis pool. The ITPs, which are updated at least annually, used for this analysis were those plans most recently completed prior to the individual's discharge from MDC.

Of the 38 individuals, three were missing ITPs and one was excluded from the analysis as its contents indicated it was not the client's most recently completed ITP. In total, 34 ITPs were reviewed for this analysis. ITPs incorporate objectives that outline clients' treatment goals. We examined all ITP objectives to determine whether they met the seven requirements outlined in federal regulations, administrative rules, and department policies and procedures. These requirements outline that objectives must:

1. Be written separately,
2. Be measurable,
3. Describe treatment methods used,
4. Identify persons responsible for ensuring implementation,
5. Include completion dates, and
6. & 7. Include the data used to measure progress and how often the data would be collected.

We examined 534 objectives to determine how many met the requirements above. Overall, we found all but one of the requirements we examined were nearly always met. Table 8 shows how many of the total objectives examined satisfied each requirement. For example, all but one objective reviewed (533 of 534, or 99.8 percent of all objectives reviewed) were written separately.

Table 8
ITP Objectives Met Nearly All Policy Requirements

Requirement	Total That Met Requirement	Percent of Total
Written as separate	533	99.8%
Measurable	521	97.6%
Include methods used	531	99.4%
Persons responsible	531	99.4%
Completion dates	531	99.4%
Type of data needed	530	99.3%
Data frequency	368	68.9%

Source: Compiled by Legislative Audit Division staff based on analysis of department documents.

The one requirement not met as consistently was inclusion of the data collection frequency; 68.9 percent of objectives reviewed met this requirement. The department confirmed this was likely due to the frequency of data collection often being built into the processes associated with each data collection method. The development process for the ITP, which is designed to guide client treatment, generally adheres to requirements.

Department Could Improve Management Information Availability

A primary purpose of this audit was to verify how former MDC clients are faring now. During our work, it was difficult for the department to describe client progress in an aggregated way. While a wide range of client care information is generated and archived by the department, it is not being used to the extent it could be to aggregate and evaluate client outcomes. How and where the department stores and uses client-related information across its units impacts the extent to which it can understand and report its effectiveness supporting adults with disabilities.

While the department engages in analysis activities, it does not have consistent or ready access to all data that could assist in further analyzing client outcomes or supporting management decisions. For example, MDC/IBC has not historically recorded incident reports in an aggregate way. Presently, incident reporting data is maintained in PDF format and not easily analyzed by department staff to assess client outcomes and progress.

We also found the department does not always leverage some available client data to examine and manage their operations. Department staff acknowledged that they would like to conduct analysis work like what we completed for this audit but indicated they do not always have the fiscal or staff resources necessary to do so to the extent

they would like. Nonetheless, during the audit, department staff indicated the IBC has recently begun developing procedures and tools to compile and track facility incident data to analyze, including tracking and trending an individual's incidents over time.

Decentralized Data Storage Creates Barriers to Management Information Use

Client data the department generates can be used to report on individual client progress and outcomes, but the decentralized way client data is stored does not lend itself to such analysis. For example, IBC staff indicated they would need to review changes across multiple client files to summarize a client's long-term treatment progress. Accessing and reviewing numerous documents in this manner is neither an efficient nor realistic approach. Further, analyzing management information could be completed in a more streamlined and efficient manner if the underlying data was generated and stored in a more consistent and centralized way.

In addition, unreliable availability of data due to inconsistent or decentralized storage methods means department management or external stakeholders cannot as readily determine whether policies, procedures, rules, or statute are being consistently followed. Providing care for a historically marginalized group of individuals comes with a high level of scrutiny from external stakeholders. That fact paired with performance management best practices require the ability to legitimize policy decisions or changes based on quality information originated from sound analysis. Much department data, in their current forms, do not lend themselves to such analysis.

Department Does Not Have Data Management Plan

One of the primary causes for lack of aggregated management information is the decentralized nature of the department's client care services, both organizationally and geographically. Multiple department units are responsible for delivering and monitoring services for adults with developmental disabilities, including the IBC and the DDP, which oversees clients receiving services the waiver. A new electronic care management system being rolled out by the department may streamline or alleviate some of these issues. However, the department will still need to develop an overarching plan or process to gather data, summarize, and assess the client outcomes over time.

Ultimately, a plan for organizing and analyzing the volume of client care information generated by or for the department would help ensure that management information is readily available to assess client outcomes and the department's performance caring for individuals with disabilities, including those who are former residents of MDC.

State Policy Requires Management to Establish Internal Controls to Assess Program Effectiveness

Per state policy, agency management is responsible for establishing and maintaining an internal control system that ensures its organization's objectives are achieved. Without reliable and consistent data analysis, organizational leaders do not have quality information to determine the organization is achieving its mission. Such information is also necessary to manage daily operations and ensure efficient and effective use of state resources.

Related specifically to serving individuals living with developmental disabilities, a national professional association for state-level directors suggested that state home and community-based waiver systems incorporate data integration processes to combine and link data from different sources to create a more comprehensive data environment. It also recommended developing protocols for data collection and aggregating, analyzing, and reporting data for stakeholders.

A data management system helps ensure reliable management information is routinely generated and available to base policy decisions on. By improving data collection and analysis systems, the department can better respond to stakeholders seeking aggregated data on the status of individuals under their care, including former MDC clients.

RECOMMENDATION #5

We recommend the Department of Public Health and Human Services Developmental Services Division develop a data management plan and processes to:

A. *Identify data needs for measuring and aggregating client outcomes,*

B. *Develop protocols for collecting reliable and accurate data,*

C. *Ensure more consistent and centralized data storage, and*

D. *Establish analysis procedures and reports to make informed management decisions and inform stakeholders on client outcomes.*

Chapter V – Costs of Serving Former MDC Clients in the Community

Introduction

While we recognize the inherent differences between the needs of and services and treatment provided to individuals in institutional and community settings, one of the primary arguments for closing the Montana Developmental Center (MDC) was it would be less expensive to serve individuals in the community. Consequently, we examined whether serving former MDC clients in the community resulted in cost savings for the state.

We found that the average annual cost for serving former MDC clients in the community under the state's 1915(c) Home and Community-Based Services Medicaid Waiver for individuals with intellectual/developmental disabilities (waiver) was lower than the average cost per client over time at MDC and the Intensive Behavior Center (IBC). During the 2015 Legislative Session, some closure proponents argued the average annual waiver costs for serving an individual in the community was around $40,000. While we found that statistic holds true, we determined the average annual waiver costs for former MDC clients to be significantly higher than the waiver-wide average.

However, we also determined that MDC's closure has resulted in annual cost savings to the state. Since the closure process began, the total costs of running Boulder and serving cohort clients in the community declined 27 percent. This chapter provides information on the work described above and includes our associated conclusions, findings, and recommendations.

Waiver Cost Plans for Former MDC Clients Significantly Higher Than Average Waiver Recipient

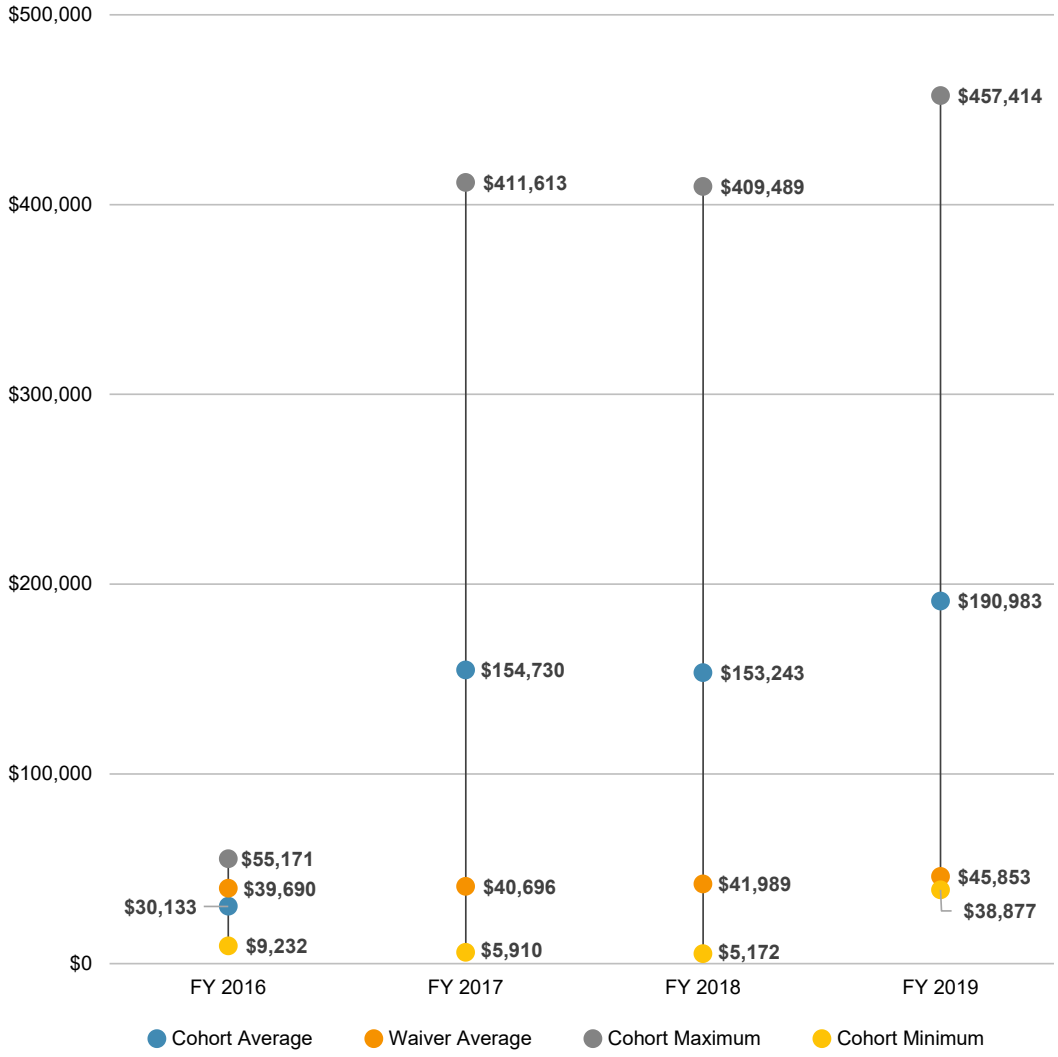
Many former MDC clients receive services under the waiver. The waiver offers over 30 service areas, such as day supports, employment support, transportation, and residential habilitation support. Waiver-enrolled individuals have Individual Cost Plans (ICPs) that reflect the cost of services necessary for them to maintain their health and safety living in the community.

We examined the ICP expenditures for the 38 of the 53 cohort clients who received waiver services between fiscal years (FY) 2016 through 2019. Expenditures reflect the total costs of services billed by providers. We compared these expenditures with waiver-wide statistics to understand how the ICPs of individuals from the cohort compare to the average waiver recipient.

In FY 2017, 29 individuals from the cohort received waiver services and made up 1.1 percent of the total waiver recipients but 4.0 percent of the total waiver expenditures for that year. For FY 2019, 36 individuals from the cohort received waiver services that year and comprised 1.4 percent of the total enrollees but 5.6 percent of total waiver expenditures. This trend reflects that individuals formerly committed to MDC generally have higher levels of service and support needs to live successfully in the community in comparison to the average waiver recipient.

Former MDC clients are diverse in their needs and the level of services needed to support them in a community setting. Figure 17 shows, for FY 2016 through 2019, the average, maximum, and minimum waiver expenditures for cohort members, as well as the total average ICP expenditures across all waiver recipients for comparison.

Figure 17
Average and Maximum Cohort ICP Expenditures for Cohort Members Exceed Waiver-Wide Average



Source: Compiled by Legislative Division Audit staff based on department data.

Note that the expenditures illustrated in Figure 17 (see page 60) represent the amount paid for waiver services each fiscal year and not necessarily the full year's ICP amount for clients; this is because clients may enter or exit the waiver mid-year.

This wide range of cohort ICP expenditures demonstrates the wide range of services and supports each individual needs to live in the least restrictive environment possible. Further, the figure also shows that clients from the cohort tend to have a higher level of service and support needs than the average waiver client, as the blue dot representing the average waiver expenditures across cohort members is higher than the orange dot showing the average waiver expenditures across its entire membership. The blue dot's average waiver expenditures increase after FY 2016 as more individuals discharged from MDC and entered waiver services.

Former MDC Clients Receive Additional Medicaid Covered Services

In order to capture a wider range of state costs related to serving former MDC clients in the community, we acquired unduplicated medical claims for a total of 36 cohort members to consider alongside waiver costs. However, Medicaid-covered medical claims alone do not represent all non-waiver expenditures the state incurs serving former MDC clients outside of IBC. For example, some individuals from the cohort not included in these calculations are currently incarcerated in the state prison or are committed to state run mental health institutions. Further, the department indicated that some former MDC clients may receive additional state-related supports, such as state supplements to their Social Security Income.

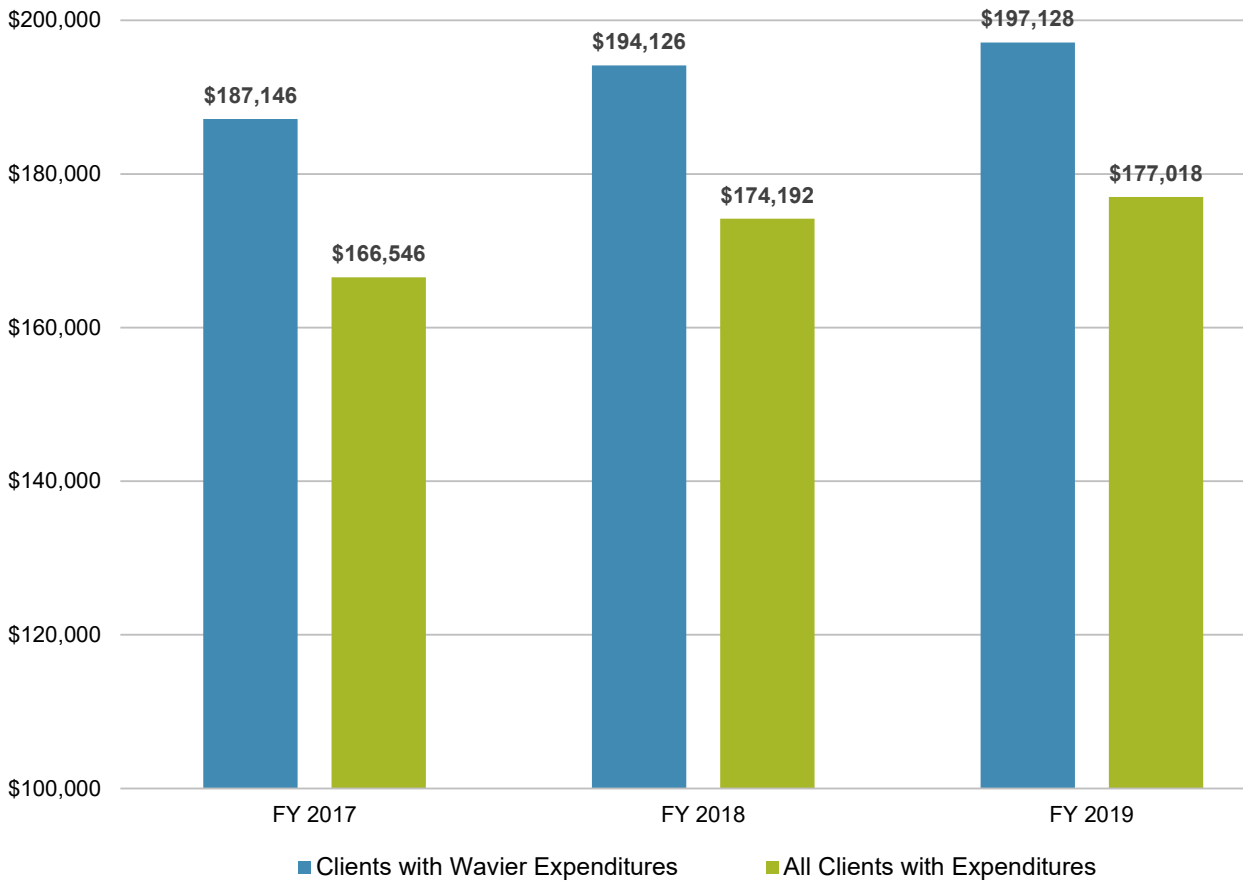
We combined all available waiver expenditures and medical claims for each client for each fiscal year between the individual's MDC discharge and fiscal year-end 2019. There were four individuals who did not have waiver expenditures but did have medical claims. We excluded individuals who had only partial-year expenditures to ensure the resulting calculations reflected average costs for a full year of services.

Figure 18 (see page 62) contains two average annual costs calculated for FY 2017 through 2019. This data set included 43 individuals who had either 1) one full year of waiver expenditures, 2) medical claims, or 3) both. Some individuals of the 46 who had medical claims did not receive waiver services. Fiscal year 2016 was not included in the analysis, as no individuals from the cohort received a full year of services that year.

There were four individuals in this analysis who had only annual medical expenses, which ranged from approximately $5 to $3,300. Because they were significantly

lower than annual waiver expenditures, these annual costs functioned as outliers that affected the group-wide average costs. As such, we completed two separate calculations for each fiscal year: one average across all full-year client expenditures and one average that excluded the four medical claims-only recipients.

Figure 18
Two Average Annual Expenditure Calculations: Cohort Clients With Only Waiver Expenditures and All Cohort Clients With Expenditures



Source: Compiled by Legislative Audit Division staff based on department data.

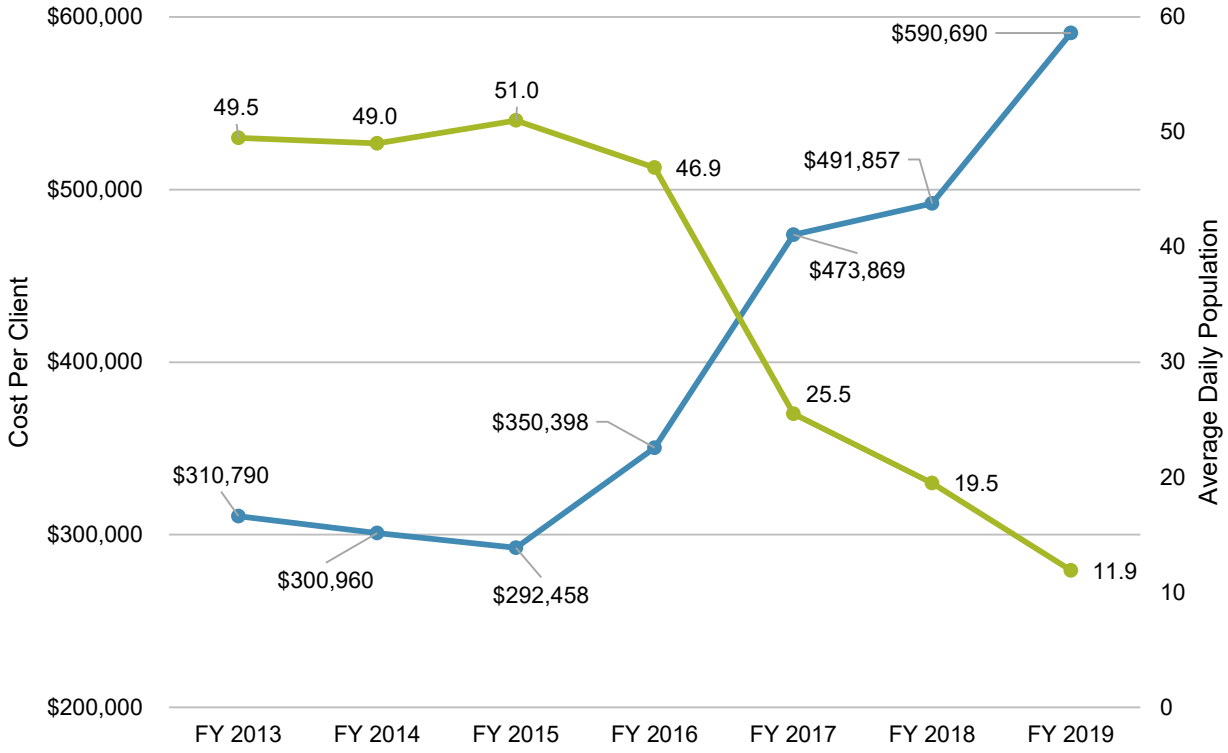
In the figure, the blue bar for each fiscal year represents the average annual cost to serve individuals enrolled in the waiver, incorporating medical claims in the total. The green bar for each fiscal year shows the average annual costs factoring in all individuals from the cohort, including those with only minimal medical claims. Both value sets demonstrate the range of supports individuals need to serve their behavioral or medical needs. This analysis was also completed in order to help determine whether it costs less, on average, to serve clients in the community versus at MDC/IBC. We discuss average MDC/IBC cost per client in the following section.

Boulder Campus' Cost Per Client Has Increased Over Time

We also calculated the cost per client for the Boulder campus over time. We used the Average Daily Population (ADP) census data, which is based on the number of individuals receiving care at MDC and the separate secure Intensive Behavior Center (formerly called the Assessment and Stabilization Unit, or ASU) each day. One potential ADP limitation is it does not incorporate care days when an individual under the facility's care is not physically present. However, the ADP data was the best option available to calculate census trends over time and was the data provided by the department when annual census data were requested.

The cost per client was calculated by dividing each fiscal year's MDC/IBC General Fund expenditures by the year's ADP for the full campus (i.e., combined census for MDC and ASU/IBC). The following figure captures the calculated cost per client by fiscal year. For FY 2019, both IBC operational expenses and Boulder campus maintenance expenditures were included. Since MDC's closure in mid-fiscal year 2018, the department has tracked separately the operational costs for IBC and costs to maintain the Boulder campus grounds, including the empty MDC facilities.

Figure 19
Boulder Campus Cost Per Client and Average Daily Population by Fiscal Year



Source: Compiled by Legislative Audit Division staff based on department and SABHRS data.

The cost per client increased during and after the MDC closure. While annual expenditures declined during and after the closure, those costs were spread across fewer clients as the census declined, as shown in the green average daily population line in Figure 19 (see page 63). The IBC expenditures cover both operational costs for the facility and fixed costs for maintaining the entire Boulder campus grounds, including the dormant MDC facilities. Barring any unforeseen needs, the department expects to spend approximately $660,000 during FY 2021 to maintain the value of the empty facilities and surrounding grounds.

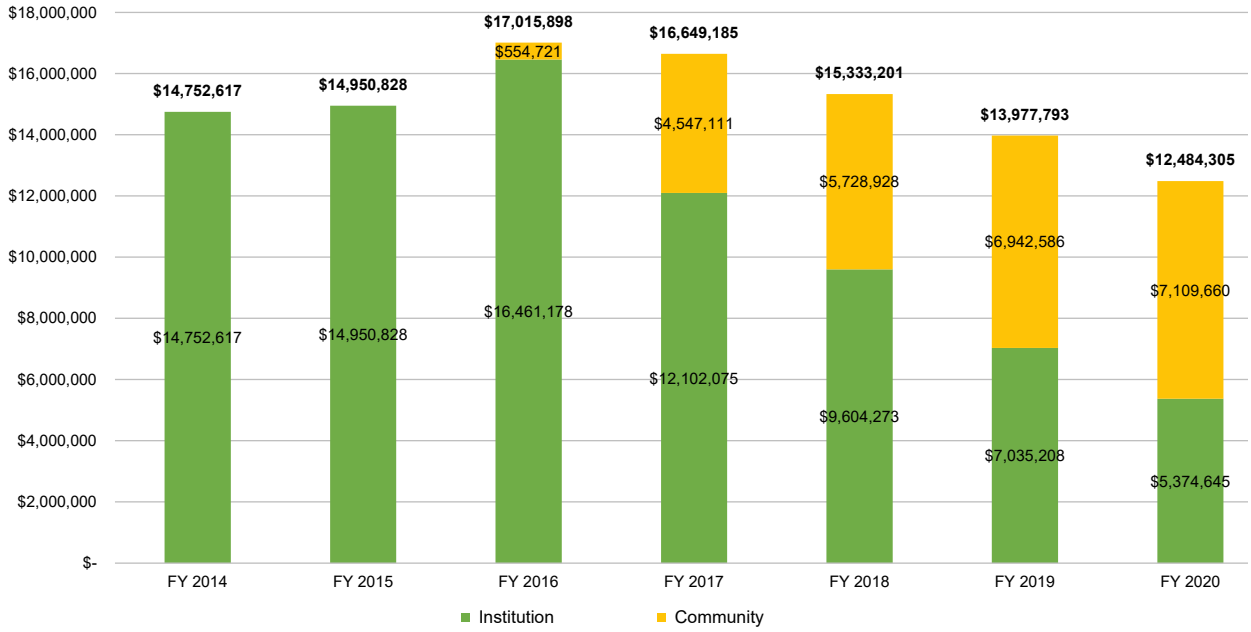
MDC Closure Led to Less Costs to Serve Cohort

We examined costs to serve cohort clients in the community and maintain the IBC over time to determine whether the state has spent less as a result of the closure. The costs we included incorporate both expenditures for running the Boulder campus and costs for serving the cohort clients in the community. While this analysis attempts to determine cost savings to the state, one limitation is that it does not incorporate the costs of serving former cohort clients in other state institutions, such as the Montana State Prison or Montana State Hospital. However, it is reflective of the current reality of providing developmental services to cohort members in both the community and institutional settings, as well as maintaining the IBC facility.

Values used to calculate total institution costs in Figure 20 (see page 65) are the expenditures for operating MDC/IBC and maintaining the Boulder campus grounds. Fiscal years 2016 through 2019 also include medical claims for the cohort individuals at MDC/IBC. Some claims in the calculation may be duplicative if they were rendered by MDC staff. Because of the original time frame of the medical claims data request, not all client medical claims may be included in the calculations. However, the overall claims values are low enough not to make a significant impact on the calculations, as total medical claims ranged from $5,500 to $35,000, depending on the year.

Values for the community costs are cohort clients' waiver expenditures and medical claims incurred after discharging from MDC. For FY 2020, both community medical claims costs and cohort waiver expenditures were estimated as they were not part of the data originally requested for the audit. To estimate waiver expenditures, we requested the total waiver expenditures for FY 2020 and made the assumptions that the same cohort members are still receiving waiver services and incurred the same percentage of total expenditures as FY 2019 (i.e., the cohort made up 5.6 percent of FY 2019's total waiver expenditures, so the FY 2020 estimate used is 5.6 percent of FY 2020 waiver expenditures). Further, the FY 2020 total waiver expenditures may be representative of but not the final total costs for that FY, as providers may invoice for FY 2020 services through the end of FY 2021.

Figure 20
Estimated Costs for Cohort and Boulder Over Time



Source: Compiled by Legislative Audit Division staff based on department and SABHRS data.

Over the closure period, the operating expenditures for the Boulder facilities declined and community costs increased as more MDC cohort clients transitioned out of the facility and into the community. However, the total costs across both settings for the facility and cohort clients in the community declined during and after the closure. Between FY 2016, the first fiscal year of the closure, and FY 2020, approximate total costs declined 27 percent.

MDC closed during FY 2019. As such, we also made a direct comparison between the FYs 2019 and 2020 and a pre-closure year to estimate the closure's potential cost savings. In examining MDC expenditures prior to closure, we determined FY 2015 was a representative benchmark of recent MDC annual costs. That year's expenditures (see Figure 20) very closely approximated the average annual costs of FY 2010 through FY 2015. Table 9 (see page 66) compares FY 2015 costs and the years in which MDC has been closed.

Table 9
MDC Closure Has Resulted in Less Costs to the State

FY 2015 Benchmark	FY 2019 Total	Difference
$14,950,828	$13,977,793	$973,035

FY 2015 Benchmark	Estimated FY 2020 Total	Difference
$14,950,828	$12,484,305	$2,466,523

Total Estimated Savings:	$3,439,558

Source: Compiled by Legislative Audit Division staff based on department and SABHRS data.

The difference in costs between the year in which MDC closed and its pre-closure average expenditures was approximately $973,000. In the first full year after MDC's closure, we calculated it cost nearly $2.5 million less to serve cohort clients in the community and maintain the IBC facility than the average pre-closure MDC costs. Assuming waiver costs remain stable over time, it is reasonable to expect the state to maintain annual savings as a result of the closure. Further, repurposing the MDC facility may also result in further cost savings if a non-state entity becomes responsible for the property. While this analysis may have limitations, as discussed, it does demonstrate that serving more clients in the least-restrictive setting possible has resulted in overall cost savings to the state.

CONCLUSION

MDC clients generally have greater service needs and, therefore, above-average waiver costs. While IBC institutional costs per client have increased due to the Boulder census declining over time, MDC's closure has resulted in overall cost savings to the state as a result of serving clients in community-based settings.

Appendices

Appendix A - Client Survey Procedures and Potential Limitations

The client survey population consisted of 29 of 51 possible individuals from the audit cohort. (Two individuals from the total cohort of 53 have since passed away.) Determining the final participant pool from the cohort was an intensive process that first involved defining initial population parameters: 1.) The individual is not currently institutionalized nor incarcerated and 2.) the individual is not deceased. These two criteria narrowed the population to 41 potential participants.

To ensure contacting these individuals would not adversely impact their lives (i.e., trigger serious maladaptive behaviors or otherwise cause severe distress), department management recommended we reach out to clients' case managers, as applicable, to learn more about the individuals, the disability or disabilities they are living with, and their perceptions on whether the individual would understand the concept of consent to participate. Several of the case managers we contacted suggested we also reach out to the individuals' community service providers and/or guardians for further input in these areas.

After discussions with case managers, community service providers, and some guardians, the prospective participant field was narrowed to 29 individuals. Clients were removed from the respondent pool at this stage for various reasons, including:

- Reports the individual would not cognitively understand consent,
- Reports of a high likelihood our reaching out to them would trigger dysregulation or severe maladaptive behaviors such as suicidal ideation, self-injurious behavior, or elopement,
- The individual's guardian requesting we do not contact the individual, or
- Reports the individual was currently experiencing severe health/medical issues.

Individuals in the cohort subpopulation not receiving waiver services (i.e., whom we did not have anyone to reach out to in advance of contacting the client) were kept in the final client survey population.

In designing the client survey, we sought advisement and feedback from the experts with whom we contracted. They provided guidance on how to increase the accessibility of the survey and how it was administered. Further, the department, including psychiatric staff who had experience working with former and current MDC/IBC

clients, also provided us with survey feedback. The resulting survey design strategies we implemented included:

- Writing questions in plain language,
- Using large font and enough spacing for written responses,
- Assigning response options corresponding icons to help convey meaning visually, and
- Separating the paper survey into three distinct packets.

All 29 prospective participants were mailed paper surveys. We also coordinated with clients' community providers to schedule times to talk with clients on the telephone to: 1) Ensure they received the paper survey, 2) Explain the survey, 3) Determine whether they were interested in participating and, if so, 4) Whether they wanted to fill out and mail back the paper survey or complete the survey over the phone with audit staff. In a few cases, based on case manager recommendations, we reached out to clients before mailing a paper survey to determine how they wanted to participate.

In the cases in which a client's provider indicated to us in advance that the client had declined to participate, we still requested a time to speak with the client on the phone to confirm this ourselves. There were two cases in which we were not able to confirm their declination. One individual declined taking our phone call and in the other case, staff reported the client declined verbally twice to talking with us.

Of importance, we emphasized several times with all individuals who agreed to participate that they were not required to do so and that if they did opt to participate, they could decline answering any question and could end their participation at any time after beginning.

One potential client survey limitation was we had little control over whether provider staff were present or involved in the survey administration process. The level of privacy available or the presence of other individuals at the time of survey participation impacts the potential for response bias among participants. In most cases when we administered the survey via telephone, staff who were present played a passive role, remaining in the room or clarifying question meaning for clients. In one case, the client requested the staff ask the survey questions rather than us. We also found some staff attempted to correct clients' answers or ask guiding questions when they may have perceived the client did not understand or answer a question accurately. For example, a client replying "No" to whether they did any additional activities outside their home, a staff asked, "What about the time you did [Additional Activity]?" To address this involvement, we recorded the client's initial answer as their survey response, as that was the most likely the answer they would have provided us in the absence of staff.

We also documented the statements made by staff, if any, and recorded the staff's role and degree to which they were involved in aiding the client. For paper survey responses, we requested information regarding who, if anyone, assisted the client in completing the survey and requested they summarize how they helped the client.

Defining the final survey population relied heavily on the accounts of case managers, provider staff, and client family and guardians to determine whether the individual would understand consent and whether us contacting the individual could lead to an adverse impact. We acknowledge this approach may have led to surveying primarily clients from the cohort with higher functional abilities, increasing the potential for loss of diversity of perspectives across the participant pool. However, this approach reflected our best ability to address concerns surrounding participatory consent and the potential for us to negatively interfere in clients' lives.

Appendix B - Client Survey Response Rate and Results

The client survey population consisted of 29 former MDC residents from the audit cohort. The table below captures the response rate and the response modes of those that participated. (Appendix A describes the population selection and administration procedures and questionnaire design considerations.)

Response Type	Total
Phone/videoconferencing	11
Paper	6
Declined	5
No response	6
Unable to participate*	1
Total Population	**9**
Total Responses	**17**
Response Rate	**58.62%**

*Due to a reported change in their health.

Question 1: How did you feel about leaving MDC?

Answer Choices	Responses	
Very good	61.54%	8
Good	23.08%	3
Not good or bad	0.00%	0
Bad	0.00%	0
Very bad	7.69%	1
Do not know	7.69%	1
	Answered	**13**
	Missing	**4**

Question 2: How did the move from MDC go for you?

Answer Choices	Responses	
Very good	33.33%	5
Good	46.67%	7
Not good or bad	13.33%	2
Bad	0.00%	0
Very bad	0.00%	0
Do not know	6.67%	1
	Answered	**15**
	Missing	**2**

Question 3: Please say more about how the move went for you.

Response Themes	Responses	
Positive Emotions/Experience • Move went well (5) • Felt happy (2)	43.75%	7
Negative Emotions/Experience • Nervous at first (1) • Move made individual angry (1) • Scared because it was a new place (1)	18.75%	3
MDC • Did not get to say goodbye (1) • Did not want to leave (1) • Did not understand why was separated from other clients (1) • Staff took individual to new home (1)	25.00%	4
Community Provider • Got to meet new people (1) • Has since moved from one community home to another (1) • Did not allow client to continue dating significant other (1) • Not providing a service discussed before the move (1) • Described where they live how (2)	37.50%	6
	Answered	**16**
	Missing	**1**

Question 4: Did you feel ready to move from MDC?

Answer Choices	Responses	
Yes	80.00%	12
No	13.33%	2
Do not know	6.67%	1
	Answered	**15**
	Missing	**2**

Question 5: Did you get to say goodbye to staff or friends at MDC before you moved?

Answer Choices	Responses	
Yes	64.71%	11
No	29.41%	5
Do not know	0.00%	0
Did not want to say goodbye	5.88%	1
	Answered	**17**
	Missing	**0**

Question 6: How did the MDC staff help you with the move from MDC? Please choose all that apply.

Answer Choices	Responses	
MDC staff answered any questions I had about the move	43.75%	7
MDC staff listened if I wanted to talk about the move	68.75%	11
MDC staff helped me pack my things	75.00%	12
MDC staff brought me to my new home	93.75%	15
Other (please explain)	37.50%	6
MDC staff did not help me with the move	0.00%	0
	Answered	**16**
	Missing	**1**

Question 7: Did you take the things you owned with you?

Answer Choices	Responses	
Yes	88.24%	15
No	11.76%	2
Do not know	0.00%	0
	Answered	**17**
	Missing	**0**

Question 8: How stressful was the move for you?

Answer Choices	Responses	
Not stressful	46.67%	7
A little stressful	26.67%	4
Stressful	6.67%	1
Very stressful	13.33%	2
Do not know	6.67%	1
	Answered	**15**
	Missing	**2**

Question 9: How did you feel when you first arrived at your new home?

Response Themes	Responses	
Positive Emotions/Experience • Felt happy (5) • Felt excited (3) • Felt good (1)	56.25%	9
Liked New Home • Liked new home (2) • Has own room or bathroom (2)	25.00%	4
Negative Emotions/Experience • Felt nervous (3) • Felt scared (1)	25.00%	4
MDC • Miss friends or staff there (2) • Did not want to leave (1) • Liked better (1)	25.00%	4
Community Provider • Visited new home before moving (1) • Got to meet new staff (1) • Thought they would have a job but did not (1)	18.75%	3
	Answered	**16**
	Missing	**1**

Question 10: Did you help pick your new home?

Answer Choices	Responses	
Yes	66.67%	10
No	33.33%	5
Do not know	0.00%	0
	Answered	**15**
	Missing	**2**

Question 11: Before COVID-19, did you get to spend time outside of your home?

Answer Choices	Responses	
Yes	100.00%	17
No	0.00%	0
Do not know	0.00%	0
	Answered	**17**
	Missing	**0**

Question 12: Which of the following activities did you do outside of your home before COVID-19? Please choose all that apply.

Answer Choices	Responses	
Work or volunteer	76.47%	13
Go on vacation	52.94%	9
Do errands (for example: grocery shopping, doctor's office, bank, post office)	82.35%	14
Go to events in the community (for example: parades, festivals, concerts)	82.35%	14
Participate in a social group (for example: church, clubs, support groups)	58.82%	10
Exercise (for example: gym, sports, walk outside, run)	88.24%	15
Do fun things (for example: movies, shopping for fun, restaurants)	94.12%	16
Visit family or friends	82.35%	14
Other (please explain)	23.53%	4
None of the above	0.00%	0
Do not know	0.00%	0
	Answered	**17**
	Missing	**0**

Question 13: Do you spend as much time outside of your home as you would like?

Answer Choices	Responses	
Yes	76.47%	13
No	17.65%	3
Do not know	5.88%	1
	Answered	**17**
	Missing	**0**

Question 14: Do you talk to your family or friends when you want to?

Answer Choices	Responses	
Yes	93.75%	15
No	6.25%	1
Do not know	0.00%	0
Do not have family or friends	0.00%	0
Do not want to talk to family or friends	0.00%	0
	Answered	**16**
	Missing	**1**

Question 15: Do you have chances to make new friends?

Answer Choices	Responses	
Yes	88.24%	15
No	5.88%	1
Do not know	5.88%	1
	Answered	**17**
	Missing	**0**

Question 16: Do you get to spend enough time with friends?

Answer Choices	Responses	
Yes	76.47%	13
No	23.53%	4
Do not know	0.00%	0
Do not have friends	0.00%	0
	Answered	**17**
	Missing	**0**

Question 17: Do your staff help you with your concerns or problems?

Answer Choices	Responses	
Yes	93.75%	15
No	6.25%	1
Do not know	0.00%	0
Do not have staff	0.00%	0
Do not want to say	0.00%	0
	Answered	**16**
	Missing	**1**

Question 18: Do you feel like your staff care about you?

Answer Choices	Responses	
Yes	94.12%	16
No	5.88%	1
Do not know	0.00%	0
Do not have staff	0.00%	0
Do not want to say	0.00%	0
	Answered	**17**
	Missing	**0**

Question 19: Can you get health care when you need it? (For example: see a doctor, nurse, dentist, eye doctor)

Answer Choices	Responses	
Yes	94.12%	16
No	0.00%	0
Do not know	5.88%	1
	Answered	**17**
	Missing	**0**

Question 20: How often do you feel safe in your home?

Answer Choices	Responses	
All of the time	31.25%	5
Most of the time	43.75%	7
Some of the time	6.25%	1
Little of the time	6.25%	1
None of the time	6.25%	1
Do not know	6.25%	1
Do not want to say	0.00%	0
	Answered	**16**
	Missing	**1**

Question 21: Before COVID-19, did you do activities that you wanted to do?

Answer Choices	Responses	
Yes	93.75%	15
No	0.00%	0
Do not know	6.25%	1
	Answered	**16**
	Missing	**1**

Question 22: Before COVID-19, did you get to pick which activities you do?

Answer Choices	Responses	
Yes	87.50%	14
No	6.25%	1
Do not know	0.00%	0
	Answered	**15**
	Missing	**2**

Question 23: If you have a job, do you like what you do?

Answer Choices	Responses	
Yes	56.25%	9
No	18.75%	3
Do not know	0.00%	0
Do not have a job	25.00%	4
	Answered	**16**
	Missing	**1**

Question 24: How happy are you?

Answer Choices	Responses	
Very happy	37.50%	6
Happy	37.50%	6
Not happy or sad	6.25%	1
Sad	0.00%	0
Very sad	6.25%	1
Do not know	12.50%	2
	Answered	**16**
	Missing	**1**

Question 25: Do you like where you live?

Answer Choices	Responses	
Yes	87.50%	14
No	12.50%	2
Do not know	0.00%	0
	Answered	**16**
	Missing	**1**

Question 26: What would make your life better?

Response Theme and Total	Responses	
Better Physical Health	6.25%	1
Freedom • To go places (1) • Have more (1)	12.50%	2
MDC • Go back to live there (1) • Say hello to friends and staff there (1)	12.50%	2
Recreational/Leisure Activities • Go camping (1) • Go gambling (1) • Go to movies (1) • Go on vacation (1) • Go shopping more when virus is over (2)	37.50%	6
Things to Make Life Better • Have a million dollars (1) • Have a phone card (1) • Have internet (1)	18.75%	3
Family/Friends • See family (2) • Have own family (1) • Help sick family (1) • Play video games with friends (1) • See friends (1) • Take friend to a theme park (1)	43.75%	7
Relationships • Have a significant other and get married (1) • Increase social/interpersonal skills (1)	12.50%	2
Be Financially Independent	6.25%	1
Have a Job	6.25%	1
Housing • Own a house and land (1) • Move to a different place (1) • Live in own apartment (1)	18.75%	3
Do Not Know	12.50%	2
	Answered	**16**
	Missing	**1**

Question 27.a1: Do you like living where you live now?

Answer Choices	Responses	
Yes	82.35%	14
No	11.76%	2
Do not know	0.00%	0
Do not want to say	5.88%	1
	Answered	**17**
	Missing	**0**

Question 27.a2: Did you like living at MDC?

Answer Choices	Responses	
Yes	18.75%	3
No	81.25%	13
Do not know	0.00%	0
Do not want to say	0.00%	0
	Answered	**16**
	Missing	**1**

Question 27.b1: Are you happy where you live now?

Answer Choices	Responses	
Yes	82.35%	14
No	5.88%	1
Do not know	0.00%	0
Do not want to say	11.76%	2
	Answered	17
	Missing	0

Question 27.b2: Were you happy at MDC?

Answer Choices	Responses	
Yes	28.57%	4
No	64.29%	9
Do not know	7.14%	1
Do not want to say	0.00%	0
	Answered	**14**
	Missing	**3**

Question 27.c1: Do you feel staff care about you where you live now?

Answer Choices	Responses	
Yes	76.47%	13
No	11.76%	2
Do not know	5.88%	1
Do not want to say	0.00%	0
	Answered	**17**
	Missing	**1**

Question 27.c2: Did you feel staff cared about you at MDC?

Answer Choices	Responses	
Yes	50.00%	8
No	37.50%	6
Do not know	12.50%	2
Do not want to say	0.00%	0
	Answered	**16**
	Missing	**1**

Question 27.d1: Do you do activities you like to do where you live now?

Answer Choices	Responses	
Yes	93.75%	15
No	0.00%	0
Do not know	6.25%	1
Do not want to say	0.00%	0
	Answered	**16**
	Missing	**1**

Question 27.d2: Did you do activities you liked to do at MDC?

Answer Choices	Responses	
Yes	60.00%	9
No	40.00%	6
Do not know	0.00%	0
Do not want to say	0.00%	0
	Answered	**15**
	Missing	**2**

Question 27.e1: Do you feel safe where you live now?

Answer Choices	Responses	
Yes	100.00%	14
No	0.00%	0
Do not know	0.00%	0
Do not want to say	0.00%	0
	Answered	**14**
	Missing	**3**

Question 27.e2: Did you feel safe at MDC?

Answer Choices	Responses	
Yes	53.33%	8
No	40.00%	6
Do not know	6.67%	1
Do not want to say	0.00%	0
	Answered	**15**
	Missing	**2**

Question 27.f1: Do you choose the activities you do where you live now?

Answer Choices	Responses	
Yes	86.67%	13
No	13.33%	2
Do not know	0.00%	0
Do not want to say	0.00%	0
	Answered	**15**
	Missing	**2**

Question 27.f2: Did you choose the activities you did at MDC?

Answer Choices	Responses	
Yes	53.33%	8
No	46.67%	7
Do not know	0.00%	0
Do not want to say	0.00%	0
	Answered	**15**
	Missing	**2**

Question 27.g1: Do you do things in the community where you live now?

Answer Choices	Responses	
Yes	93.75%	15
No	6.25%	1
Do not know	0.00%	0
Do not want to say	0.00%	0
	Answered	**16**
	Missing	**1**

Question 27.g2: Did you do things in the community while living at MDC?

Answer Choices	Responses	
Yes	37.50%	6
No	56.25%	9
Do not know	6.25%	1
Do not want to say	0.00%	0
	Answered	**16**
	Missing	**1**

Question 27.h1: Do you like spending time with the people you live with now?

Answer Choices	Responses	
Yes	93.75%	15
No	0.00%	0
Do not know	0.00%	0
Do not want to say	6.25%	1
	Answered	**16**
	Missing	**1**

Question 27.h2: Did you like spending time with the people you lived with at MDC?

Answer Choices	Responses	
Yes	47.06%	8
No	52.94%	9
Do not know	0.00%	0
Do not want to say	0.00%	0
	Answered	**17**
	Missing	**0**

Question 28: Is there anything else you would like to tell us?

Response Themes	Responses	
How They're Doing Now • Doing well (1) • Has a list of other places they're interested in living at (1) • Owns a pet now (1) • Likes both MDC and current placement (1)	25.00%	4
MDC – Life at MDC • Did not do things there (1) • Did not give clients freedom they deserved (1) • Did not have a happy life there (1) • Enjoyed time there (1) • Had a job that paid wages there (1) • Job there entailed landscaping, recycling, and laundry (1)	37.50%	6
MDC – Closure • Some people still need MDC for help (2) • Feel bad about closure (1) • Closure happened too quickly (1) • People lost jobs due to closure (1) • Happy it closed (1)	37.50%	6
MDC – Safety • Some staff were abusive (1) • Some staff were fired due to mistreating clients (1) • Was injured there (2)	25.00%	4
MDC – People • Says hello to people there (3) • Wants people from MDC to visit (1)	25.00%	4
Community Provider • Very good people there (1) • Feel like staff no longer care (1) • Wants to leave provider (1)	18.75%	3
Health • Physical ailment hurts all the time (1) • Was sick in the hospital (1)	12.50%	2
Survey • Thinks some of their answers may have been wrong (1) • Wanted to know if we liked their responses (1)	12.50%	2
No Other Comments	12.50%	2
	Answered	**16**
	Missing	**1**

29. Please choose the answer(s) that describe how you completed the survey:

Answer Choices	Responses	
I answered the survey by myself. I was not assisted by another person.	25.00%	4
I was assisted by another person: Staff member	68.75%	11
I was assisted by another person: Family member	0.00%	0
I was assisted by another person: Friend	0.00%	0
I was assisted by another person: Other (please explain)	6.25%	1
A person responded on my behalf: Staff member	0.00%	0
A person responded on my behalf: Family member	0.00%	0
A person responded on my behalf: Friend	0.00%	0
A person responded on my behalf: Other (please explain)	0.00%	0
	Answered	**16**
	Missing	**1**

Appendix C - Natural Supports Survey Procedures and Potential Limitations

Natural supports are family members, guardians, friends, or others in an individual's interpersonal sphere who support or have relationships with the individual without being paid to do so. The natural supports survey population consisted of 43 individuals who were legal guardians not associated with advocacy groups or natural supports for an individual in the cohort of 53 clients. The survey was mailed to clients in hard copy form. Audit staff followed up via telephone with 17 recipients who had not returned their survey close to the submission deadline to determine their interest in participating.

The natural supports questionnaire was designed to parallel as closely as possible the questions asked in the client survey. While the questions between the two surveys were not identical in how they were written, they were developed to retain as much fidelity to the thematic concepts and content above as possible. This approach was taken to compare clients' responses against their natural supports' responses, should corresponding responses be received.

Eighteen natural supports responded to the survey for a response rate of 42 percent. Seventeen respondents returned copies of the paper survey and one survey was administered over the phone. Two surveys were undeliverable without updated addresses available, and these respondents did not return follow-up phone calls. One individual declined to participate. Among the 22 nonrespondents, 18 percent lived out of state. Further, none of the three respondents who were legal guardians through adult protective services responded to the survey. Not hearing about the opinions and experiences of these nonrespondents may have an impact on the results, as their responses may have served to further diversify and provide varying insight into the topics and themes raised in the survey.

Multiple natural supports of one individual client were offered the opportunity to participate, leading to the potential of "many to one" representation between natural supports and clients. In analyzing responses, this occurred once: two respondents supported the same client, meaning the 18 respondents supported a total of 17 different former clients. Both response sets were included in the final analyzed data. While incorporating both sets of responses in the analysis could lead to an minor amplification of certain response trends, an examination of the two response sets showed that some answers between the two individuals were similar, but they were not identical in their perceptions so both response sets were kept in the analysis.

Appendix D - Natural Supports Survey Response Rate and Results

The natural supports population consisted of 43 natural supports of individuals from the cohort of 53. The table below captures the response rate and the response modes of those that participated. (Appendix A describes the population selection and administration procedures.)

Response Type	Total
Phone	1
Paper	17
Declined	1
No response	22
Undeliverable	2
Total Population	**43**
Total Responses	**18**
Response Rate	**41.86%**

Question 1: How do you feel about the decision to close the Montana Developmental Center (MDC)?

Answer Choices	Responses	
Agree	20.00%	3
Disagree	40.00%	6
I do not have an opinion	40.00%	6
	Answered	**15**
	Missing	**3**

Question 2: If anything, what went well in the process of moving from MDC?

Response Themes	Responses	
Client happy or doing well	13.33%	2
Kept informed	6.67%	1
Nothing	13.33%	2
Obtained placement	6.67%	1
Process went well	20.00%	3
Satisfied with placement • Located closer to family (1)	26.67%	4
Staff were helpful • MDC staff were helpful (1) • Provider staff were helpful (1) • Staff not specified (2)	26.67%	4
Do not know	6.67%	1
	Answered	**15**
	Missing	**3**

Question 3: If anything, what would have improved the process of moving from MDC?

Response Themes	Responses	
Dissatisfaction with closure; client should not have moved	7.69%	1
Dissatisfaction with community provider • Need better facility (2) • Staff lack necessary training (1) • Not offering services promised at time of transition (1)	38.46%	5
MDC staff involving family more in process	15.38%	2
Having more provider options	7.69%	1
Move sooner	7.69%	1
Nothing	7.69%	1
Placement closer to family	7.69%	1
Do not know	7.69%	1
No opinion	7.69%	1
	Answered	**13**
	Missing	**5**

Question 4a: The move was **____ for the individual**.

Answer Choices	Responses	
Difficult	33.33%	6
Somewhat difficult	5.56%	1
Not difficult	38.89%	7
Do not know	22.22%	4
	Answered	**18**
	Missing	**0**

Question 4b: The move was _____ **for you**.

Answer Choices	Responses	
Difficult	22.22%	4
Somewhat difficult	33.33%	6
Not difficult	27.78%	5
Do not know	16.67%	3
	Answered	**18**
	Missing	**0**

Question 5: Did you have the opportunity to help choose the place that the individual moved to from MDC?

Answer Choices	Responses	
Yes	44.44%	8
No	50.00%	9
Not applicable	5.56%	1
	Answered	**18**
	Missing	**0**

Question 6: In your opinion, how helpful were **MDC staff** in **planning** the individual's transition to their new home?

Answer Choices	Responses	
Not helpful	5.56%	1
A little helpful	11.11%	2
Somewhat helpful	5.56%	1
Helpful	22.22%	4
Very helpful	22.22%	4
Do not know	22.22%	4
Not applicable	11.11%	2
	Answered	**18**
	Missing	**0**

Question 7: In your opinion, how helpful were **MDC staff** to the individual when the individual **was moving** to their new home?

Answer Choices	Responses	
Not helpful	11.11%	2
A little helpful	11.11%	2
Somewhat helpful	5.56%	1
Helpful	27.78%	5
Very helpful	22.22%	4
Do not know	16.67%	3
Not applicable	5.56%	1
	Answered	**18**
	Missing	**0**

Question 8: In your opinion, how helpful were **community provider staff** in **planning** the individual's transition to their new home?

Answer Choices	Responses	
Not helpful	11.11%	2
A little helpful	11.11%	2
Somewhat helpful	11.11%	2
Helpful	5.56%	1
Very helpful	22.22%	4
Do not know	38.89%	7
Not applicable	11.11%	0
	Answered	**18**
	Missing	**0**

Question 9: In your opinion, how helpful were **community provider staff** to the individual when they **moved** into their new home?

Answer Choices	Responses	
Not helpful	16.67%	3
A little helpful	0.00%	0
Somewhat helpful	16.67%	3
Helpful	11.11%	2
Very helpful	22.22%	4
Do not know	33.33%	6
Not applicable	0.00%	0
	Answered	**18**
	Missing	**0**

Question 10: In your opinion, how well does the individual's **community provider** meet their needs?

Answer Choices	Responses	
No needs met	12.50%	2
A few needs met	12.50%	2
Some needs met	31.25%	5
Most needs met	12.50%	2
All needs met	18.75%	3
Do not know	12.50%	2
Not applicable	0.00%	0
	Answered	**16**
	Missing	**2**

Question 11: Before COVID-19, was the individual included in the community (i.e., the world outside of their home)?

For example, did they spend time in public spaces? Did they meet new people? Did they do activities with others who are not living in their home?

Answer Choices	Responses	
Yes	72.22%	13
No	22.22%	4
Do not know	5.56%	1
	Answered	**18**
	Missing	**0**

Question 12: Which type of opportunities did the individual have to spend time outside of their home before COVID-19?

Answer Choices	Responses	
Work or volunteer	61.11%	11
Go on vacation	33.33%	6
Do errands (for example: grocery shopping, doctor's office, bank, post office)	88.89%	16
Go to events in the community (for example: parades, festivals, concerts)	38.89%	7
Participate in a social group (for example: church, clubs, support groups)	50.00%	9
Exercise (for example: gym, sports, walk outside, run)	72.22%	13
Do fun things (for example: movies, shopping for fun, restaurants)	66.67%	12
Visit family or friends	61.11%	11
Other (please explain)	5.56%	1
None of the above	0.00%	0
Do not know	5.56%	1
	Answered	**18**
	Missing	**0**

Question 13: Was it easy for you to reach the individual when you wanted to speak with or see them before COVID-19?

Answer Choices	Responses	
Yes	77.78%	14
No	22.22%	4
Do not know	0.00%	0
	Answered	**18**
	Missing	**0**

Question 14: Do you believe the individual feels comfortable in their home?

Answer Choices	Responses	
Yes	77.78%	14
No	22.22%	4
Do not know	0.00%	0
	Answered	**18**
	Missing	**0**

Question 15: Do you believe the provider support staff address the individual's concerns?

Answer Choices	Responses	
Yes	76.47%	13
No	23.53%	4
Do not know	0.00%	0
Individual does not have staff	0.00%	0
Individual does not have a provider	0.00%	0
	Answered	**17**
	Missing	**1**

Question 16: Do you believe the provider support staff care about the individual?

Answer Choices	Responses	
Yes	77.78%	14
No	11.11%	2
Do not know	11.11%	2
Individual does not have staff	0.00%	0
Individual does not have a provider	0.00%	0
	Answered	**18**
	Missing	**0**

Question 17: Do you believe the individual is currently receiving adequate medical services?

Answer Choices	Responses	
Yes	83.33%	15
No	5.56%	1
Do not know	11.11%	2
	Answered	**18**
	Missing	**0**

Question 18: Do you believe the individual is currently receiving adequate social services (for example: counseling/therapy, vocational training)?

Answer Choices	Responses	
Yes	66.67%	12
No	22.22%	4
Do not know	11.11%	2
	Answered	**18**
	Missing	**0**

Question 19: Do you believe the individual is safe in their home?

Answer Choices	Responses	
Yes	72.22%	13
No	27.78%	5
Do not know	0.00%	0
	Answered	**18**
	Missing	**0**

Question 20: Before COVID-19, did the individual get to do activities they like to do?

Answer Choices	Responses	
Yes	66.67%	12
No	16.67%	3
Do not know	16.67%	3
	Answered	**18**
	Missing	**0**

Question 21: Is the individual allowed to make choices about the activities they do?

Answer Choices	Responses	
Yes	68.75%	11
No	0.00%	0
Do not know	31.25%	5
	Answered	**16**
	Missing	**2**

Question 22: In your opinion, how happy is the individual?

Answer Choices	Responses	
Very happy	16.67%	3
Happy	50.00%	9
Not happy or unhappy	16.67%	3
Unhappy	5.56%	1
Very unhappy	5.56%	1
Do not know	5.56%	1
	Answered	**18**
	Missing	**0**

Question 23: In your opinion, does the individual like where they live?

Answer Choices	Responses	
Yes	81.25%	13
No	12.50%	2
Do not know	6.25%	1
	Answered	**16**
	Missing	**2**

Question 24: Do you have opportunities to participate in the individual's plan of care to the extent you want?

Answer Choices	Responses	
Yes	61.11%	11
No	27.78%	5
Do not know	5.56%	1
Not applicable	5.56%	1
	Answered	**18**
	Missing	**0**

Question 25: What do you think could make the individual's life better?

Response Themes	Responses
Family • Live closer to them (3) • More unsupervised time with them (1)	4
Financial education	1
Have more freedom/ability to come and go	1
More Chances for Activities • Outdoor activities (1)	2
More structured environment like MDC	1
Nothing - Individual's life is good	1
Community Provider Improvements • More transportation opportunities (1) • Need enough staff (1) • Need better staff training (1)	3
Do not know	3
Answered	**13**
Missing	**5**

Question 26.a: Which place do you think the individual prefers to live?

Answer Choices	Responses	
Where they currently live	52.94%	9
MDC	35.29%	6
They are about the same	5.88%	1
Do not know	5.88%	1
	Answered	**17**
	Missing	**1**

Question 26.b: The individual is happier at:

Answer Choices	Responses	
Where they currently live	58.82%	10
MDC	23.53%	4
They are about the same	11.76%	2
Do not know	5.88%	1
	Answered	**17**
	Missing	**1**

Question 26.c: The staff cares about the individual more at:

Answer Choices	Responses	
Where they currently live	37.50%	6
MDC	25.00%	4
They are about the same	12.50%	2
Do not know	25.00%	4
	Answered	**16**
	Missing	**2**

Question 26.d: The individual receives better medical services at:

Answer Choices	Responses	
Where they currently live	56.25%	9
MDC	25.00%	4
They are about the same	12.50%	2
Do not know	6.25%	1
	Answered	**16**
	Missing	**2**

Question 26.e: The individual receives better social services (for example: counseling/ therapy, vocational training) at:

Answer Choices	Responses	
Where they currently live	43.75%	7
MDC	18.75%	3
They are about the same	12.50%	2
Do not know	25.00%	4
	Answered	**16**
	Missing	**2**

Question 26.f: The individual is safer at:

Answer Choices	Responses	
Where they currently live	41.18%	7
MDC	23.53%	4
They are about the same	23.53%	4
Do not know	11.76%	2
	Answered	**17**
	Missing	**1**

Question 26.g: The individual has more activities to do at:

Answer Choices	Responses	
Where they currently live	58.82%	10
MDC	35.29%	6
They are about the same	5.88%	1
Do not know	0.00%	0
	Answered	**17**
	Missing	**1**

Question 26.h: The individual has more freedom at:

Answer Choices	Responses	
Where they currently live	58.82%	10
MDC	29.41%	5
They are about the same	11.76%	2
Do not know	0.00%	0
	Answered	**17**
	Missing	**1**

Question 26.i: The individual interacts more with people in the community at:

Answer Choices	Responses	
Where they currently live	64.71%	11
MDC	29.41%	5
They are about the same	0.00%	0
Do not know	5.88%	1
	Answered	**17**
	Missing	**1**

Question 27: How well do you know the individual?

Answer Choices	Responses	
I know them very well	94.12%	16
I know them well	5.88%	1
I am familiar with them	0.00%	0
I do not know them well	0.00%	0
	Answered	**17**
	Missing	**1**

Question 28: How often do you speak with the individual?*

Response Themes	Responses	
Daily	44.44%	8
Weekly	33.33%	6
Monthly	5.56%	1
Regularly	11.11%	2
Not applicable (individual is not verbal)	5.56%	1
	Answered	**18**
	Missing	**0**

*This was an open-ended question.

Question 29: Is there anything else that you would like to tell us?

Response Themes	Responses	
Individuals' Service Needs Vary • Residential service type should depend on individual's disabilities; no one size fits all (1) • Community placement is not best for everyone (1)	13.33%	2
MDC • Appreciation for MDC (1) • Closure was bad decision (2) • Closure was political (2) • Should re-open (1) • Poorly run (1) • Staff mistreated client (1) • Staff needed better training (1)	60.00%	9
Community Provider: • Appreciation for provider (2) • Individual likes/doing well there (2) • Less freedom there than at MDC (1)	33.33%	5
Individual has not learned to take responsibility for maladaptive behaviors	6.67%	1
Happier now that they left MDC	6.67%	1
Individual is respondent's child	6.67%	1
No	13.33%	2
	Answered	**15**
	Missing	**3**

Department of Public Health and Human Services

Department Response

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Department of Public Health and Human Services

Director's Office ♦ PO Box 4210 ♦ Helena, MT 59620 ♦ (406) 444-5622 ♦ Fax: (406) 444-1970

Greg Gianforte, Governor

Adam Meier, Director

May 04, 2021

RECEIVED
May 04, 2021
LEGISLATIVE AUDIT DIV.

Angus Maciver
Legislative Auditor
Office of the Legislative Auditor
State Capitol, Room 160
Helena, Montana 59620-1705

Re: Performance Audit of "Montana Developmental Center Closure and Client Transition."

Dear Mr. Maciver:

The Department of Public Health and Human Services has reviewed the *Performance Audit of Montana Developmental Center Closure and Client Transition* completed by the Legislative Audit Division. Our responses and corrective action plans for each recommendation are provided below.

Recommendation #1:
We recommend the Department of Public Health and Human Services adhere to state law by developing and implementing a process to report clients' monitoring results to guardians and family members authorized to receive the information.

Response: Concur

Corrective Action: *The Department implemented a process to report clients' monitoring results to guardians and family members authorized to receive the information in December 2020.*

Planned Completion Date: *Completed December, 2020*

Recommendation #2:
We recommend the Department of Public Health and Human Services develop a formal plan for repurposing the MDC facility that identifies key action steps, timelines, benchmarks to measure step completion, and parties responsible for each step.

Response: Partially Concur

Corrective Action: *On April 12th, Governor Gianforte signed an executive order transferring the vacant MDC facility and campus to the Department of Justice. Due to the timeframe of the transfer,*

developing a formal plan with key action steps, timelines, and benchmarks, etc. is no longer possible as the plan has already been executed.

Planned Completion Date: *Completed April, 2021*

Recommendation #3:
We recommend that the Department of Public Health and Human Services work with the Department of Justice to develop and maintain a memorandum of understanding that clearly defines agency and staff roles, expectations, and processes for Intensive Behavior Center incident reporting.

Response: Concur

Corrective Action: *The department will engage the Department of Justice and work to develop and implement a memorandum of understanding.*

Planned Completion Date: *December, 2021*

Recommendation #4:
We recommend the Department of Public Health and Human Services:

A. Update and centralize policies, procedures, and/or administrative rules for Personal Support Plans to increase administrative efficiencies, ensure greater consistency, and meets its mission of person-centered planning.
B. Provide ongoing, statewide training for case managers and providers regarding policies, procedures, and administrative rules.
C. Monitor Personal Support Plans for adherence to requirements to help ensure ongoing person-centered planning across regions and providers.

Response: Concur

Corrective Action: *During the 66th legislative session, Senate Bill 5 passed requiring the Department to review administrative rules, policies, and procedures with providers of community developmental disability services. This work group convened in September of 2019 and is currently updating Personal Support Plan policies, procedures, and administrative rules. The work group will be developing statewide training for case managers and providers regarding updated administrative rules, polices, and procedures when the process is finalized. Additionally, the department will ensure all requirements identified in Personal Support Plan policy, procedure, and administrative rules are incorporated into existing monitoring processes.*

Planned Completion Date: *June, 2022*

Recommendation #5:

We recommend the Department of Public Health and Human Services Developmental Services Division develop a data management plan and processes to:

A. Identify data needs for measuring and aggregating client outcomes.
B. Develop protocols for collecting reliable and accurate data.
C. Ensure more consistent and centralized data storage.
D. Establish analysis procedure and reports to make informed management decisions and inform stakeholders on client outcomes.

Response: Concur

Corrective Action: *In February 2021, the Developmental Disabilities Program transitioned into a comprehensive care management system that has the capacity to improve data management, as all member data will exist in a single system. The department will use this improved access to data to develop and implement a data management plan that will incorporate the above recommendations.*

Planned Completion Date: *December, 2021*

Sincerely,

Adam Meier, Director
Department of Public Health and Human Services

cc:
Marie Matthews, Medicaid and Health Services Branch Manager
Erica Johnston, Operations Services Branch Manager
Rebecca de Camara, Disability Services Division Administrator
Lindsey Carter, Developmental Disabilities Program Bureau Chief
Chad Hultin, Audit Liaison